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ABSTRACT

This handbook provides information about emotional, behavioral, and learning and developmental disabilities; disability-specific entitlements; and approaches for professionals who work with youthful offenders with disabilities throughout the juvenile process. Chapter 1 describes characteristics of common disabilities among youthful offenders and details strategies and accommodations that professionals may want to consider when working with the youth who have these disabilities. Disabilities described include conduct disorder, depression, post traumatic stress disorder, attention deficit hyperactivity disorder, oppositional defiant disorder, learning disabilities, and developmental disabilities. Case studies of individuals with different disabilities are provided, as well as a list of some of the communication difficulties confronted by individuals with mental retardation. Chapter 2 reviews entitlements for youth with disabilities in the justice system, including rights under the Individuals with Disabilities Education Act (IDEA). Chapter 3 outlines strategies that professionals can use for promoting family involvement. A final chapter makes recommendations for overcoming the barriers in the juvenile justice system that make it more difficult for youth with disabilities to receive appropriate and meaningful correctional responses. An appendix provides a resource list of national organizations related to youth and juvenile justice and a list of parent training and information centers. (Contains 69 references.) (CR)

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Unique Challenges, Hopeful Responses

A Handbook for Professionals Working with Youth with Disabilities in the Juvenile Justice System

Second Edition

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UNIQUE CHALLENGES, HOPEFUL RESPONSES

A Handbook for Professionals Working with Youth with Disabilities in the Juvenile Justice System

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Contents

Preface iv

Introduction 1

Chapter I—Common Disabilities Among Youthful Offenders: Accommodations in the Justice Process 4

Conduct Disorder 5

Depression 11

Case Study: Allie 15

Post Traumatic Stress Disorder (PTSD) 16

Attention Deficit Hyperactivity Disorder (ADHD) 18

Case Study: Jeff 22

Oppositional Defiant Disorder (ODD) 23

Learning Disabilities (LD) 25

Developmental Disabilities (DD) 29

Communication Difficulties Confronted by Individuals with Mental Retardation 35

Questions to Ask If You Suspect a Defendant Has Mental Retardation 36

Case Study: Ben 37

Chapter II—Entitlements for Youth with Disabilities in the Justice System: Individuals with Disabilities Education Act (IDEA) 38

Chapter III—Promoting Family Involvement 52

Chapter IV—Systems and Services: Looking to More Hopeful Responses 56

Systems and Service Problems in the Juvenile Justice System 57

Conclusion 64

Appendix 65

Resource List of National Organizations Related to Youth and Juvenile Justice 65

References 69

Parent Training and Information Centers 74

Preface

In 1994, PACER Center began its project on Youth with Disabilities in the Juvenile Justice System. Interest in the needs of this population originated in PACER's Abuse Prevention Project, where staff found a distinct link between child maltreatment and subsequent criminal behavior. Also, PACER advocates documented an increasing number of requests for assistance regarding the special education needs of adjudicated youth. With assistance from The McKnight Foundation and the Jay and Rose Phillip Family Foundation, PACER initiated an examination of the unique needs of young offenders with disabilities within the context of current theory and research regarding juvenile delinquency.

Parents, professionals, and organizations like PACER continue to strive for a more thorough understanding of youth with disabilities who are over-represented in the juvenile justice system. This book is intended to encourage those working with youth to consider approaches that are both rehabilitative and disability-sensitive. Drawing upon PACER's history of serving youth with disabilities on a range of issues, this book can be used as a guide to address the unique disability-related needs of those young persons involved in the justice system.

Introduction

Youth with disabilities are represented in the juvenile justice system in numbers disproportionate to their incidence in the general population.

Most youth with disabilities do not develop criminal behavior. However, youth with emotional and behavioral disorders, learning disabilities, and developmental disabilities are represented in the juvenile justice system in numbers disproportionate to their incidence in the general population. It may be that more than half, or as much as 90 percent, of youth in the justice system meet the diagnostic criteria for one or more disorders (Nelson, 1995; Otto, 1992). A 1995 survey of adolescents in corrections settings and adolescents in public schools indicates that more than twice as many of the adolescents in corrections had been placed in special education classes for learning problems (Harrison, Fulkerson & Beebe, 1996). In fact, another study has determined that over 98 percent of juvenile offenders entering adult correctional facilities were high school dropouts (Ingersoll & LeBoef, 1997).

While the presence of a disability is not an excuse or rationalization for unlawful activity or an exemption from consequences, it *does* mean:

- If a youth's behaviors are characteristic of a disability, he or she may require a disability screening and evaluation;
- If a youth's disability interferes with his or her capacity to participate meaningfully in the justice process, he or she has a right to have the proceedings adapted to the needs stemming from the disability; and
- If there is a formal diagnosis of a disability, a youth may be entitled to specific services relative to the disability while in a correctional program, including aftercare.

Issues regarding youth with disabilities involved in the juvenile justice system are complex and interconnected, requiring the expertise and cooperation of professionals from many different fields. In addition, appropriate treatment requires that professionals have an understanding of diverse systems, cultures, laws, and approaches to working with youth at risk (Benjamin, 1997). To participate effectively as members of multidisciplinary teams, all must share at least a basic understanding of the many issues that can have an impact on a youth's life. Questions to consider include:

- What are the characteristics of a specific disability, and how do they affect typical functioning for the youth? Might illegal behavior, or charges of illegal behavior, relate to the presence of a disability?

- How can the youth with a disability be appropriately served in school, in court, or in a correctional setting?
- Has the youth been attending school regularly? Did he or she receive special education and related services while in school? Is there an Individual Education Program (IEP) Plan or other education plan, and does it need to be reviewed?
- Has medication been prescribed and monitored? Is medication currently being used?
- Does the youth have mental health issues such as substance abuse or depression?
- What is family life like for the youth? Has he or she been abused or neglected? Has he or she witnessed domestic violence or violence in his or her neighborhood?
- Have the youth's needs been assessed and addressed using culturally competent approaches? Has someone from the youth's race or culture contributed to the assessment and case planning processes?
- What resources are available to the youth, the family, the correctional program and the community?

Research has well documented that child abuse and neglect, domestic abuse, poverty, substance abuse, racism and community violence are common risk factors among all juvenile offenders.

The issues are many and, individually or combined, can significantly affect the life of a youth. Research has well documented that child abuse and neglect, domestic abuse, poverty, substance abuse, racism and community violence are common risk factors among all juvenile offenders (Blumstein, 1995; Earls, 1991; Harrison, Fulkerson & Beebe, 1996; Hernandez et al., 1993; "Survey" in MHNA, 1996).

Professionals working with juvenile offenders with disabilities must also be aware of the potential impact risk factors may have on a youth and on desired correctional outcomes. Multidimensional approaches may be necessary to lessen the effects of multiple complex risks faced by many young offenders. Individual Service Plans (ISP's), IEP's, "wraparound,"* and other integrated service approaches are some ways to address multiple issues from a variety of perspectives. Specific interventions include multisystemic therapy, which examines the youth's experience in all of his or her environments, and restorative justice, which focuses on the youth's making reparation for his or her offenses. Working with an understanding of the unique needs of a youth with a disability in the justice system, professionals can more effectively apply their expertise within a comprehensive context of each youth's life.

*"Wraparound" services are coordinated services across agencies that are provided in the child's normal environment whenever possible.

This book includes information about emotional, behavioral, learning, and developmental disabilities; disability-specific entitlements; and approaches for professionals who work with youthful offenders with disabilities throughout the juvenile justice process. These professionals include law enforcement officers; prosecutors; defense attorneys; probation officers; dispositional advisors; juvenile court referees and judges; city, county, and residential corrections staff; employers and work-release staff; social service and mental health providers; special and regular education professionals; advocates; and clergy and other religious leaders.

This information can be utilized at each step in the juvenile justice process including those formal proceedings that:

- *investigate* a youth's possible involvement in a delinquent or criminal offense, including intake and interrogation
- *result in arrest* of a youth suspect
- *determine* whether charges will be made against a youth
- *decide* if a case is referred to juvenile court or to an alternative or diversion program
- *adjudge* a youth's innocence or guilt
- *develop* correctional interventions or consequences
- *select* the setting(s) in which correctional programming will take place
- *provide for* implementation and monitoring of the correctional case plan

The following chapters focus on those disabilities most common among juvenile offenders that can be addressed in special education law through the Individuals with Disabilities Education Act (IDEA). There is a range of disabilities not addressed in this publication but also present among adjudicated youth including traumatic brain injury (TBI), pervasive developmental disabilities (PDD), and anxiety disorders. For more information, see the Appendix or contact PACER Center.

Chapter I

Common Disabilities Among Youthful Offenders: Accommodations in the Justice Process

With adequate information about the range of disabilities common among youthful offenders, professionals can provide meaningful interventions and appropriate accommodations to them within the justice system. However, there are no definitive responses. Each youth manifests a disability in ways that are unique to that youth. Many youth with disabilities also have additional coexisting disabilities, compounding the challenges experienced by professionals working with them. Combined with the impact of other risk factors in a youth's life, disabilities in this population are among the most difficult to identify, diagnose, treat, and respond to effectively.

The Americans with Disabilities Act (ADA), Title II, prohibits state and local governments from discriminating against people on the basis of a mental or physical disability. State and local court systems are required not to discriminate against people with disabilities. It is important that court personnel, attorneys, and judges understand that reasonable accommodations must be made in policies and practices to ensure that an individual is not subject to discrimination based on disability.

The most common disorders among youthful offenders in the justice system include conduct disorder, depression, attention deficit/hyperactivity disorder (ADHD), learning disabilities (LD), post traumatic stress disorder (PTSD), and developmental disabilities (DD), including mental retardation and autism. Common characteristics of these disabilities, and approaches and accommodations professionals may consider when working with youth who have these disabilities, are discussed in the pages that follow.

Conduct Disorder

Conduct Disorder is the most commonly diagnosed behavioral disorder among delinquent youth. Although conduct disorder is not specifically addressed in the Individuals with Disabilities Education Act (IDEA), a number of studies have shown that between one-third and one-half of all youth diagnosed with conduct disorder also have coexisting diagnoses of attention deficit hyperactivity disorder and learning disabilities (Barkley, 1997; Shamsie *et al.*, 1996). However, they may qualify for special education services because these disorders interfere with their learning and their behaviors. At least half of the youth in correctional institutions are believed to have conduct disorder (Nelson, 1995; Otto, 1992).

According to the 1994 edition of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV):*

"The essential feature of Conduct Disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. These behaviors fall into four main groupings: aggressive conduct that causes or threatens physical harm to other people or animals . . . nonaggressive conduct that causes property loss or damage . . . deceitfulness or theft . . . and serious violation of rules. . . . The behavior pattern is usually present in a variety of settings such as home, school, or the community." (85)

Depending on the level of severity (mild, moderate, or severe), a youth with conduct disorder may engage in a range of behaviors, including some that cause relatively minor harm to others. Some youth may have difficulty feeling or expressing remorse for misbehavior and often will not take responsibility for their actions. Destruction of property can include vandalism and arson. Deceitful behaviors can include lying, theft, shoplifting, and forgery. Other features of this disorder can include bullying, threatening or intimidating behavior, extortion, initiation of physical fights, cruelty to animals, and cruelty to others perceived as weaker. Physical violence can include rape and sexual assault (Cantwell, 1994; *DSM-IV,* 1994; Walker, 1995).

Typically, a youth with conduct disorder misreads social cues and misinterprets the typical actions of others as being aggressive. For example, if someone accidentally bumps into him or her, the youth may shove back. He or she is likely to have assumed the bump was intentional, thus justifying an aggressive response. Additionally, the

youth may perceive hostility in others' behaviors and in situations where typical peers would not.

A youth with conduct disorder may also experience frequent conflict in interactions with those in authority as well as with peers, with conflicts escalating routinely. He or she has limited tolerance for frustration, tendencies toward impulsive and risky behaviors, and frequent temper outbursts. These behaviors are often repeated in multiple environments.

Because of these aggressive and destructive behaviors, a youth with conduct disorder may be rejected by his or her peers. The resulting ostracism and social isolation can lead to seeking out peers with behaviors similar to his or her own (August, 1995; Walker, 1995).

According to *DSM-IV* (1994):

"Conduct Disorder is often associated with an early onset of sexual behavior, drinking, smoking, use of illegal substances, and reckless and risk-taking acts. . . . Suicidal ideation, suicide attempts, and completed suicide occur at a higher than expected rate. . . . Academic achievement, particularly in reading and other verbal skills, is often below the level expected on the basis of age and intelligence and may justify the additional diagnosis of a Learning or Communication Disorder." (87)

Males with conduct disorder typically exhibit more aggressive behaviors than their female counterparts. These can include school discipline problems, fighting, and stealing. Females typically run away from home, use drugs, and engage in prostitution (August, 1995; *DSM-IV*, 1994; Walker, 1995).

Conduct disorder can be divided into two types:

1. **Childhood Onset, or Early Starter**, diagnosed as young as three or four years old. These youth have at least one characteristic of conduct disorder before age ten and have met the criteria for this diagnosis before puberty.
2. **Adolescent Onset, or Late Starter**. These youth, whose defiant behaviors emerge in early adolescence, exhibit no diagnostic criteria for conduct disorder before age ten (August, 1995; *DSM-IV*, 1994).

Childhood Onset (Early Starter) Conduct Disorder

A child as young as age three with behaviors typical of conduct disorder is more likely to continue the behaviors throughout childhood and into adolescence at a higher frequency and a more severe level of delinquency (Earls, 1991). Developmentally inappropriate aggressive behaviors may become apparent on the playground and surface during attempts at early problem solving and negotiating. Common behaviors include severe temper tantrums, whining, hostility towards school and authority figures, and not cooperating with rules (Arllen et al., 1994; Cantwell, 1994; Robins, 1991). Youth with conduct disorder diagnosed since early childhood, predominantly male, are most difficult to treat once they have become seriously involved in criminal behavior (Barkley, 1997; Constantino, 1992; Earls, 1991).

Adolescent Onset (Late Starter) Conduct Disorder

Youth whose conduct disorder manifests in adolescence differ from early starters in the following ways:

- They tend to be less aggressive and nonviolent
- Their behavior does not persist over a long period of time
- They relate better with peers and their family than do early starters
- They are represented equally among both males and females
- Their illegal behavior is more closely linked to impulsivity, defiance, and the influence of peer pressure
- Their families have fewer chronic problems
- They are more amenable to interventions such as mentoring and community involvement programs (August, 1995; Bloomquist, 1996; Walker, 1991, 1995)

In both types of conduct disorder, it is common to have coexisting disorders, including attention deficit hyperactivity disorder (ADHD), depression, and learning disabilities (Barkley, 1997; Offord, 1994). According to Shamsie et al. (1996), approximately 35 percent of youth with conduct disorder also have ADHD and reading disabilities.

Multiple studies of youth diagnosed with conduct disorder at a young age reveal that the diagnosis remains stable over time (Offord, 1992; Walker, 1991). For example, in one study 45 percent of those with conduct disorder at ages four through 12 still qualified for the diagnosis four years later. Nearly half also had one or more additional psychiatric disorders (Offord, 1992).

Youth with conduct disorder for whom treatment has not been successful may grow up to exhibit the adult form of conduct disorder known as Antisocial Personality Disorder. Most studies of chronic and dangerous adult offenders indicate that they are diagnosed with Antisocial Personality Disorder in addition to other serious mental health problems (Robins, 1991). Antisocial behaviors may be ameliorated when early intervention strategies involving the family, school, and peers are applied (Barkley, 1997; Shamsie, 1996; Walker, 1995).

Working with Youth Who Have Conduct Disorders

Youth with conduct disorder, particularly from the age of 14 years, can be among the most difficult youth with whom to work. Their behaviors can be defiant, resistant, destructive, manipulative, and dishonest, and it can be a challenge to reach out to them.

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As a youth with conduct disorder tends toward conflictive interactions in more than one environment, those working with him or her should avoid engaging in the conflict a youth may attempt to create. Professionals may experience their interactions to be marked by lies, emotional outbursts, and apparent lack of remorse for any misbehavior. A youth with conduct disorder may misread a professional's attempts to assist him or her throughout the justice process and will often exhibit frustration at each step. Professionals need to keep in mind that these behaviors may be manifestations of a disability. With firmness and consistency, professionals can instead focus on assisting the youth to have a clear understanding of the justice process, their options, consequences for misbehavior, and correctional goals based on building academic skills, functional life skills, and family and community relationships.

When working with a youth with conduct disorder:

- Anticipate the behaviors common to conduct disorder and purposefully address them in developing corrections and probation plans.
- Clearly establish your professional role with the youth: Why are you working with him or her? Why do you need information from the youth, and what will you do with it? Be honest about his or her potential options throughout the justice process.
- Set clear, specific limits on behaviors, explain that behaviors will be strictly monitored, and clarify consequences for noncompliance.

- Prepare youth in advance for meetings and hearings with judges and others. Ask them to reflect on their own behaviors and appearance and their impact on others (e.g., gang symbols or colors). Suggest appropriate alternatives.
- Where appropriate, consider restorative justice and family group conferencing measures that may assist the youth in understanding the impact of their crime and the importance of accepting responsibility for their actions.
- When working with a younger offender, stress the long-term consequences of continued criminal involvement.
- Consider ways, such as role playing, to support and reinforce skills that may prepare the youth to resist negative peer and family influences.
- Never call the youth derogatory names or comment negatively on their appearance or the way they speak (unless they speak disrespectfully). Ignore provocative behavior and dress.
- Juvenile offenders with conduct disorder may have difficulty acknowledging learning problems. Help them examine their learning needs and consider technical, vocational, and other alternative education programs.
- Establish a working relationship with the school, family members or surrogate, and other service providers who will be needed to monitor the youth and provide long-term support and guidance.
- Identify activities in which a youth can become involved and build self-esteem.
- Above all, be honest, firm, and consistent. Assure youth you will "hang in there" with them.

When determining correctional consequences for a youth with conduct disorder, court personnel should consider:

- The age of the youth at onset of conduct disorder-related delinquent behaviors and his or her criminal history;
- The impact of coexisting disorders such as depression and learning disabilities;
- Identifying and involving family members and other significant individuals to support the youth in treatment, correctional, and probation programming; and
- Identifying previous interventions used with a youth and determining their effectiveness.

Conduct disorder, particularly when combined with other disabilities, can be extremely challenging for even those who specialize in this disorder. However, interventions that focus on consistency, learning readiness, educational incentives, and parental or other adult involvement have been shown to increase a youth's competence, commitment to school, and trust in working with systems. Additionally, programs that are small; involve family members; regularly gather family and professionals together for planning and consultation; and provide academic, vocational and mental health services have demonstrated success in reducing juvenile delinquency in these youth (August, 1995; Heggenler, 1997; Walker, 1991, 1995). Approaches like these, which address the needs of a youth in all of his or her environments, have a greater chance for success than those directed exclusively at a youth's behaviors (Barkley, 1997; Heggenler et al., 1995).

When developing correctional strategies for a youth with conduct disorder, professionals should consider the youth's tendency to engage in more negative behaviors when in contact with more problematic peers in corrections as well as in aftercare settings. Intensive monitoring of the youth may be needed. In fact, Offord (1994) and Walker (1995) propose placing a strong emphasis on approaches that *help a youth resist involvement with delinquent peers as well as attain vocational competencies and academic success.*

Program components and service approaches to consider for youth who have conduct disorder include the following:

- A goal-oriented and supportive educational program based on a youth's strengths and needs, including assessment and special education services;
- Vocational and other functional skills training;
- Social skills, life skills, and behavior management training;
- Support, individual and family counseling, and education on living with conduct disorder;
- Problem solving, reasoning, and conflict-resolution skills development;
- Opportunities for a youth to contribute to the community, such as through service projects; and
- Empathy modeling by professionals working with a youth.

If parental supports to the youth are not available or reliable, efforts should be made to link the youth with trained mentors or others familiar with this disability who can provide guidance and encouragement.

Depression

Depression is the most common type of mood or affective disorder. According to the *DSM-IV* (1994), mood disorders can be classified into two major types, unipolar depressive disorder (clinical depression) and bipolar disorder (manic depressive disorder).

Unipolar or clinical depression and its signs often go unrecognized. They include:

- Inability to take pleasure in school, social activities, and hobbies
- Chronic feelings of hopelessness and worthlessness
- Loss of energy, constant tiredness
- Lack of appetite, excessive overeating, significant weight gain, or loss or failure to make expected weight gain
- Passive suicide attempts (risk-taking behaviors that could end in death not directly by one's own hand)
- A "pulling away" from long-held friends (i.e., social withdrawal)
- Psychomotor agitation or retardation
- Frequent thoughts of death or suicide or suicide attempts
- Physical symptoms such as headaches and stomachaches (*DSM-IV*, 1994; Garfinkel, 1994; Jensen, 1995; Slaby & Garfinkel, 1995).

It is not unusual for a youth diagnosed with clinical depression to also have attention deficit/ hyperactivity disorder, school refusal, eating disorders, learning disabilities, substance abuse, or conduct disorder.

If a youth has at least four of these symptoms over a period of two weeks or longer, he or she should be assessed by a physician or a mental health professional or both.

It is not unusual for a youth diagnosed with clinical depression to also have attention deficit hyperactivity disorder, school refusal, eating disorders, learning disabilities, substance abuse, or conduct disorder. Conversely, a youth with any of these disorders may also be misdiagnosed with depression. The difficulty in assessment arises from the presentation of features common to all of these disorders, including symptoms of sadness. For example, a high percentage of youth with conduct disorder also have diagnoses of depression (Milberger et al., 1995). The depression may be more difficult to identify with youth who have aggressive or destructive behaviors. One distinction is that a youth with depression and conduct disorder may more frequently direct those behaviors against himself or herself, while a youth with conduct disorder alone is more likely to direct his or her behaviors outwardly.

There are many ways a youth with depression can express the disorder. These include lying, running away, promiscuity, early sexual activity, substance abuse and overdosing, truancy and gambling, among others (Garfinkel, 1994). Treatment for most youth with depression includes either counseling or a combination of medication and counseling.

Bipolar Disorder or Manic-Depressive Disorder is a more severe and less common form of depression in youth. Bipolar disorder is characterized by symptoms that include an alternating pattern of emotional highs (manic episode) and emotional lows (depressive episode). Symptoms can include:

- Psychotic behavior (stemming from thoughts that seem to be out of touch with reality)
- Increased risk for suicidal behaviors
- Irritability
- Hyperactivity
- Uncontrollable spending
- Rapid talking and body movements
- Abuse of chemical substances
- Compulsive and promiscuous sexual behaviors (Adapted from *DSM-IV*, 1994.)

A manic phase is always followed by severe clinical depression (Jensen, 1995). Bipolar disorder is treatable with antidepressant medications in combination with counseling.

Working with Youth Who Have Depression

Behaviors common to a youth with depression may be misinterpreted by those working with him or her as disinterest or insolence. Professionals must be persistent in engaging and monitoring the youth even when he or she shows no signs of cooperation or acknowledgment. A youth with depression, who may also have conduct disorder, Oppositional Defiant Disorder (ODD), or other disruptive behaviors, can express the depression in a variety of problematic behaviors not typically identified as depression. As a result, the depression may be overlooked and remain unaddressed or untreated (Jensen, 1995).

When working with a juvenile offender with depression, professionals need to be aware that arrest and incarceration can result in increased feelings of shame, hopelessness, and isolation for an already troubled youth. Furthermore, if a youth was abusing substances at the time of arrest, the resulting aftereffects of withdrawal can intensify the symptoms of depression (Rowan et al., 1995).

Professionals can assist a youth with diagnosed depression by:

- Consulting with psychiatrists and other mental health professionals treating the youth's depression and integrating treatment strategies, medication information, and monitoring into correction and probation plans
- Connecting the youth with supportive resources on depression, such as written materials, support groups, etc.
- Encouraging the youth to become involved in outlets such as art, drama, music, journaling, physical activities, and recreational programs
- Assisting the youth in self-identifying signs of depression and considering options to pursue when depression sets in. If the youth has been involved with substance abuse, help him or her understand the connection between substance abuse and depression
- Acknowledging the youth's depression, telling the youth you are open to hearing him or her share her feelings
- Immediately notifying a mental health professional if you notice an abrupt or extreme change in the youth's behavior, or if he or she is talking about suicide
- Encouraging the youth to persevere, recognize, and celebrate small steps toward progress. Help others who know or work with the youth to do the same
- Contacting state, county, or local mental health departments or agencies for assistance if the youth is not working with a mental health professional

One survey of youth in correctional facilities showed that both female and male offenders were nearly two-and-one-half times as likely as students in public school to report they had attempted suicide.

Studies of correctional populations have shown that the suicide rate among incarcerated juvenile offenders is significantly higher than that of the general population. One survey of youth in correctional facilities showed that both female and male offenders were nearly two and one-half times as likely as students in public school to report they had attempted suicide (Harrison, Fulkerson & Beebe, 1996). It is also known that the suicide rate is higher for youth incarcerated in adult facilities (Lester & Danto, 1993). To respond effectively, professionals need to consider most suicide attempts as failed suicides and not as attention-seeking behavior.

A comprehensive suicide prevention plan in corrections settings includes:

1. A written plan available to all professionals for identifying and responding to youth with suicidal tendencies.
2. Staff training on identifying and responding to risks and indicators of depression.
3. Admission screening for youth with depression.
4. Frequent monitoring of juveniles identified as being at risk for suicide (Parent et al., 1994).

Case Study: Allie

"Allie" is a 16-year-old girl, the oldest of four children. Her parents both work and live in a comfortable suburb. They are committed to their children, their church, and their community.

From an early age, Allie's school experience was frustrating. No matter how hard she tried, she barely passed math and composition. Although her parents were supportive, they agreed with the teachers who said she was not trying hard enough.

When she was in the sixth grade, her parents were told to retain her for a second year as a sixth grader because she wasn't "mature enough" to begin junior high. She was not referred for an evaluation of her learning needs or special education services. By then Allie's academic disparity from her friends was becoming more severe.

Allie began to hang out with other youth who were poor students. They spent much of their time smoking, drinking, shoplifting, and skipping school. Her parents tried to be understanding; they met with a counselor and tried to forbid her to spend time with her new friends, but nothing changed.

When Allie and a friend were picked up for shoplifting in a video store, they told the police it was just an initiation into a school sorority, not a real crime. They returned the videos and were banned from returning to the store, but no charges were filed.

Allie's parents did not understand their daughter's change in behavior. In counseling sessions they felt they were being blamed for pressuring her because she wasn't a high achiever. Still, counselors recommended no formal academic or psychological evaluation.

Over the next six months Allie was arrested for curfew violations, shoplifting, and drinking. Community service was imposed but never supervised. Finally, Allie was sentenced to a juvenile facility after being in the getaway car in a robbery with four youth, all older than she was. In the small, structured environment, Allie attended classes and seemed to be doing well, until she abruptly ran away. She was traced to the emergency room of a hospital after taking an overdose of Tylenol. At that point she was given a complete psychological assessment. It was only then that her learning disability was discovered. She was also pregnant, severely depressed, and very frightened.

Allie had a miscarriage halfway through her pregnancy. Following several months of therapy and rest, she was enrolled in a small parochial school. She is now receiving special education services part of the day in a public school setting and is making slow progress with her school and home routine. Her teachers, her counselor, and her family all see her as very unlikely to get in trouble with the law again.

Post Traumatic Stress Disorder (PTSD)

Post Traumatic Stress Disorder (PTSD) is a condition that can include unrelenting, intense, and long-lasting feelings of helplessness, numbness, stress, and anxiety. It can develop in response to severe, painful experiences in a youth's life. These can include but are not limited to:

- Being a victim of kidnapping, terrorism or hostage situations
- Sexual, physical or emotional abuse
- Natural disasters (earthquake, flooding, etc.)
- Being a victim or witness of domestic violence, rape, murder, or suicidal behaviors
- Being a victim of neighborhood or community violence
- Being a victim of or witness to a severe accident
- Life-threatening illness (Pynoos, 1990; *DSM-IV*, 1994)

Many juvenile offenders have experienced or witnessed at least one of these violent situations. One study found that 41 percent of youth in the juvenile justice system had PTSD (Nelson, 1996).

The severity of trauma experienced by a youth is influenced by his or her perceptions of, and capacity to recover from, the incident(s) and can vary from youth to youth and incident to incident. A young child's PTSD is typically expressed through anger, fearfulness, distractibility, flashbacks, nightmares, eating problems, physical complaints, intrusive thoughts, jumpiness, and psychological isolation. An adolescent with PTSD may have some of these symptoms as well as feelings of guilt and hopelessness. He or she may act out sexually, engage in reckless or violent behaviors, drop out of school, or approach conflict resolution with violence (Pynoos, 1990).

Intensive long-term counseling, often in combination with medication, is the most common treatment. However, even with treatment, a youth with PTSD may continue to experience periodic symptoms for many years.

Working with Youth Who Have Post Traumatic Stress Disorder

When working with a youth with PTSD, professionals need to consider the following:

- Assist the youth in feeling comfortable while relating traumatizing events, avoid emotional responses, and assure the youth that the trauma was not her or his fault.
- Refer the youth to mental health professionals who specialize in PTSD.
- Coordinate the youth's case plans with other agencies working with his or her family or other significant adults.
- Help the youth express feelings through appropriate outlets such as play, art, writing, music, sports, and drama.

Working with Youth Who Have Conduct Disorders, Depression, and PTSD

Coordinated interventions that combine the expertise and resources of the family, school, and community are most effective with these youth. Approaches can include:

- Adapting communication and instruction to the disability
- Educating the youth in self-awareness of mental health issues
- Avoiding confrontational approaches and attempting to involve the youth in examining their behavior and its consequences
- Consistent reinforcing of positive behaviors
- Teaching conflict resolution skills
- Training youth, family members, and professionals in conflict resolution, mediation, and alternatives to violent behaviors
- Social skills training
- Involving the youth in pro social and mentor programs
- Parent training and support

Integrating these approaches in the youth's education programs has significantly reduced school suspensions in some schools (August, 1995; Barkley, 1997; Dikel, 1995).

When appropriate, supportive approaches are formally in place, consistent monitoring, staff guidance, and staff support are needed to ensure that correctional programs can continue to meet the often overwhelming needs of these youth.

Attention Deficit Hyperactivity Disorder (ADHD)

Attention deficit hyperactivity disorder (ADHD) appears at a rate of 3 to 5 percent among public school adolescents as compared to 46 percent among youth in the juvenile justice system (*DSM-IV*, 1994; Nelson, 1996). This disorder is difficult to define due to the range and various combinations of symptoms that can be present. In addition, ADHD often coexists with other emotional, behavioral, learning, and developmental disabilities, making detection and diagnosis particular challenging. For example, conduct disorders coexist in over 45 percent of youth with ADHD, and learning disabilities coexist in 20 to 80 percent (Barkley, 1997; Cantwell, 1994; D'Alonzo, 1996). Speech and language disorders are also strongly associated with ADHD (Cantwell, 1994).

The *DSM-IV* (1994) describes attention deficit hyperactivity disorder as having three subtypes:

1. Primarily inattentive (ADD, without hyperactivity);
2. Primarily hyperactive-impulsive; and
3. Combined type.

Most youth with ADHD who are involved in the juvenile justice system fall into the combined type of classification (Barkley, 1997; Bloomquist, 1996). This disability is more prevalent in males than in females, with hyperactivity a more common behavior in males and inattentiveness more common in females (Barkley, 1997; Brier, 1989). In fact, females may be less likely than males to be diagnosed with ADHD because their behaviors tend to be less disruptive (Barkley, 1997; Dikel, 1996). In addition to school failure and poor self-esteem commonly experienced by youth with ADHD, the following characteristics intrinsic to this disability present unique risks for a youth's criminal involvement.

- **Impulsivity**

Impulsivity is one of the most common behavioral characteristics of ADHD. Impulsivity interferes with the ability of a youth to be reflective. In the need for immediate gratification, a youth with ADHD may act first and think later. This impulsivity may play an important role in risk-taking or criminal behaviors. A youth may not consider beforehand that what he or she is about to do may be illegal. Also, a frequently low tolerance for frustration, linked to the inability to delay gratification, contributes to impulsive choices.

- **Irritability and Defiance**

Some youth with ADHD may be argumentative, defiant, and challenging; they may have a low tolerance for authority and consistently refuse to comply with parents, teachers, and other authority figures. Diagnoses of Oppositional Defiant Disorder (ODD) and conduct disorder often coexist with ADHD (Satterfield, 1993). As many as 60 percent of youth with ADHD may also have ODD (Barkley, 1997).

- **Hyperactivity**

Hyperactivity in a youth may be characterized by an inability to be physically still for a sustained period of time and to stay on task in school and in other activities. He or she may appear to be restless and impatient.

- **Inattentiveness**

A youth may daydream, look or walk around, or even wander out of a room. He or she may appear to be careless in his or her work. Others may assume he or she is lazy or is choosing not to listen or cooperate. A youth may appear to "tune out" or attempt to do too many things at once instead of completing or sustaining focus on one activity. Similarly, a youth may be easily distracted off task by noises or other nearby activities or conversations.

- **Disorganization**

A youth with ADHD may forget homework, lose papers, and fail to keep track of or to complete assignments. He or she often has difficulty setting priorities, planning, developing organizational strategies independently, or breaking down tasks into manageable portions.

- **Delayed Social Skills**

More than half of all youth with ADHD are developmentally immature, resulting in delayed social skill acquisition. These youth experience frustration in ongoing social interactions, may have difficulty developing friendships, and may have problems interpreting social cues (August, 1995; Barkley, 1997).

Working with Youth Who Have Attention Deficit Hyperactivity Disorder

Stressful situations, such as those experienced by a youth in an interrogation or adjudication process, can exacerbate those behaviors that are common in a youth with ADHD. Increased irritability and defiance in a youth might be expected and may make the processes more challenging for everyone involved.

Professionals may consider the following approaches and procedures when working with a youth who has ADHD:

- Collect as much information as possible about the youth before the first meeting.
- Establish some rapport with the youth to reduce the potential for defiance or obstinate behaviors.
- Suspend judgment about a youth and the crime(s) committed or alleged. Perceived blame may provoke negative behaviors. Youth with ADHD often have low self-concept and may tend toward a "self-fulfilling prophecy." That is, their behavior may reflect what they believe others expect of them.
- Anticipate but do not provoke problematic behaviors that may stem from the disability.
- Don't overrepresent your power in the justice system. It may initiate a power struggle with the youth; instead, defer to the judge as the final authority.
- Avoid reacting to a youth's "testing" behaviors. Resist interpreting negative behaviors as personal affronts.
- Sit near a door and walk out for a break if the youth's anger or frustration is building up to aggressive or attacking behaviors.
- Avoid lectures. Be clear and honest with the youth about possible options available to him or her. Explain exactly what will happen in the process as well as possible consequences if he or she is not able to cooperate. Follow-through is important.
- If a youth's interactions do not clearly indicate he or she understands what you are communicating, try another way to express it (rephrase, use a pencil and paper, role-play, etc.). For example, a youth's behaviors that may be interpreted as insolence may in fact be a language communication disability coexisting with the ADHD.

Programs that may be more effective with youth with ADHD could include the following components:

- Realistic, clearly defined behavioral expectations that are frequently repeated and reinforced;
- Small, structured environments and tasks that adapt to individual learning styles;
- Cognitive behavior therapies (Bloomquist, 1996);
- Instruction, including role-playing, in developing coping strategies for impulsivity and defiance;

- Assistance in identifying and integrating strategies that promote organizational skills, task completion, and reflective behaviors;
- Team experiences that promote social integration and modeling of appropriate social skills;
- Structured group activities that enable youth with differing skills and skill levels to work together toward a common goal;
- Activities, such as karate and tae kwon do, that promote concentration, discipline and taking direction from an authority figure (August, 1995);
- Structured time and focused activities;
- Medications combined with other treatment interventions; and
- Frequent exercise.

Case Study: Jeff

"Jeff" is a 15-year-old boy who was diagnosed with ADHD when he was 8 years old. Although medication helped him to focus and to reduce his impulsive behaviors, Jeff did not like the side effects, so he stopped taking it in junior high. He has been unwilling to work with school counselors to develop strategies that might help him succeed academically.

Jeff's most recent IEP was completed in eighth grade. His mother requested additional testing at that time because of his poor academic performance, but it was not provided. She did not know that she could appeal this decision. He is currently in the tenth grade but at the bottom of his class. His mother suspects he is at least two or three grade levels behind in some subjects. He has failed science and math. His best subjects are art and writing. School officials refer to his high IQ as evidence that he just does not try. He has had continuing difficulties at school with swearing, aggressive behaviors, and truancy.

After repeated truancy and curfew violations, Jeff was sentenced to a small facility in his home state. The program was understaffed; it housed primarily older, more violent adolescent offenders and was run according to a rigid military model.

While at the facility, Jeff was befriended by a 17-year-old streetwise offender with a long criminal record. Together, they ran away, stole a car, and led police on a high-speed chase. Jeff had no explanation for his involvement in what he knew to be a crime. Like his previous truancy, curfew violations, and school lapses, Jeff just did not "think about" what he was doing.

Because of his attempted escape, Jeff could not return to the same facility. Instead he was sent to an out-of-state facility. Neither of his parents is able to visit Jeff there because of the expense. They rely primarily on infrequent phone calls to stay in contact with their son. It is unclear how much academic instruction he is receiving, since the staff insist they are providing four hours of class time a day, but Jeff tells his parents that all he does is watch television. The staff seem to know nothing about his diagnosis of ADHD.

Jeff's parents were recently advised that he would be released at the end of the school year. With the assistance of an advocate, they have requested his academic records but have not received them. The post-release treatment plan consists of weekly meetings with a probation officer. Despite repeated calls, the probation officer has never been in touch with Jeff, either parent, or the school. His school has told Jeff's parents that they will not take him back because they feel it is not an appropriate setting for someone with his record.

Oppositional Defiant Disorder (ODD)

More than 60 percent of youth with ADHD also have Oppositional Defiant Disorder (ODD) (Barkley, 1997). Typically, ODD, which is common among juvenile offenders, also exists with other disorders which can be addressed in correctional programs through the IEP.

ODD is expressed as a recurrent pattern of negativistic, defiant, disobedient, and hostile behaviors toward authority figures. Those behaviors can include:

- Anger
- Arguing
- Defiance and refusal to comply or cooperate
- Deliberate annoyance
- Shunning personal responsibility and blaming others for mistakes and misbehaviors

These behaviors are similar, but not as severe, as those found in a youth with conduct disorder and generally do not include aggression toward people and animals, destruction of property, repeated theft, or chronic lying and deceit (*DSM-IV*, 1994).

Working with Youth Who Have Oppositional Defiant Disorder

Severe responses tend to escalate the power struggles provoked by a youth with ODD.

The behaviors of a youth with oppositional defiant disorder, as well as those disabilities that commonly coexist with it, are so challenging and provocative that one might be tempted to respond with severe consequences in order to "teach that kid a lesson" and help him or her to "remember who's in charge." In fact, severe responses can have just the opposite effect on youth with ODD and tend to escalate the power struggles provoked by a youth with this disability. As with many of the approaches suggested for youth with ADHD, approaches to consider for youth with ODD focus away from engaging with their negative behaviors. Avoid emotional interactions. Respond to negative behaviors with clear, direct communication of necessary information, expectations, consequences, and goals.

In developing correctional strategies for a youthful offender with oppositional defiant disorder, the following considerations should be included:

- Develop strategies that incorporate consequences as quickly as possible following unacceptable behavior. Goals should directly address the youth's defiant behaviors.
- Determine whether the youth may have any coexisting diagnoses that need to be addressed. Prior records may be accessed from other systems, such as special education or child protection.
- Vocational assessment and job placement goals should be a priority.
- Link youth and family with appropriate resources.
- Identify opportunities for peer learning, team activities, mentor programs, or the arts.
- Develop opportunities for youth to make reparations to the community, if necessary. Identify and arrange for opportunities for community service projects.
- Assist the youth and his or her parents to access information that will provide them with a thorough understanding of the disability and opportunities to learn how to interact with their youth more effectively.
- Provide or arrange for ongoing natural supports and possible in-home counseling for the youth and family.
- Integrate behavior strategies in the school and community so that expectations are consistent.

Learning Disabilities (LD)

According to the *DSM-IV* (1994), disorders known as learning disabilities (LD) are diagnosed when

"The individual's achievement on individually administered, standardized test in reading, mathematics, or written expression is substantially below that expected for age, schooling, and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical, or written skills. . . . Learning Disorders must be differentiated from normal variations in academic attainment and from scholastic difficulties due to lack of opportunity, poor teaching, or cultural factors." (46-47)

Additionally, IDEA (1997) specifies that learning disabilities are disorders of one or more basic psychological processes involved in understanding and using written or spoken language and which result in an impaired ability to listen, think, speak, read, spell, or do mathematical calculations. Specific learning disabilities include dyslexia, dysgraphia, dyscalcula, and perceptual disorders.

Learning disabilities include one or more of the following characteristics:

- Difficulties with translating oral language into information, resulting in inappropriate or contradictory responses to instructions, questions, and persons in authority
- Poorly developed social skills, which result in a lack of understanding of social cues, giving the impression of being discourteous and headstrong (Waldie & Spreen, 1993)
- Poor impulse control
- Poor choices in peer relationships
- Risk-taking behaviors
- Lack of commitment to school
- Lack of success in managing the disability (August, 1995; Bailen, Mann & Springer, 1996; *DSM-IV*, 1994; Lewcowicz, 1996; Spekman, 1993)

For a youth with learning disabilities, poor academic achievement is often in direct contrast to his or her high intelligence. Due to inconsistent academic achievement, a youth with LD is often described as "lazy, unmotivated, inattentive, and not working to potential" (Bailen, Mann & Springer, 1996). Learning disabilities are often referred to as "invisible disabilities" because they are physically unidentifiable.

The prevalence of learning disabilities varies widely from source to source. According to Bailen, Mann & Springer (1996), 10 to 20 percent of students in regular education have LD. The *DSM-IV* (1994) estimates that approximately 5 percent of students have been identified as having LD but up to 10 percent may have the disorder and not be diagnosed. Shepherd & Zaremba (1995) cite estimates of LD among students to be anywhere from 1 through 30 percent. However, in the juvenile justice system, approximately 36 percent of youth have LD (Brier, 1994). If they have a coexisting disorder such as ADHD or conduct disorder, the proportion is even higher.

Many youth with LD remain unidentified or misdiagnosed (Dikel, 1995). In one study of juvenile corrections, 50 percent of the youth tested were found to have previously undetected LD (LDA of CA, 1996).

In one study of juvenile corrections, 50 percent of the youth tested were found to have previously undetected learning disabilities.

Youth with learning disabilities are twice as likely to commit a delinquent offense than their non-learning-disabled peers (Brier, 1989). Those who have LD coexisting with ADHD are at highest risk for offending due to their more disruptive and noncompliant behavior (Brier, 1994). Furthermore, language-based LD impacts both comprehension and judgment with more profound verbal deficits often resulting in more aggressive behaviors. This may result in greater difficulties with problem-solving, anticipating consequences and moral reasoning (Brier, 1989). Learning disabilities also often coexist with other behavioral disorders such as ADHD and ODD. The LD may go undetected as behavioral characteristics may interfere with its diagnosis.

If a youth cannot understand or master a particular learning task, he or she may lose interest in the subjects he or she is failing. He or she may not complete assignments or may seem to ignore deadlines. It is not unusual for a youth with learning disabilities to fail some subjects and excel at others. When LD is not identified and a youth does well in some subjects and poorly in others, parents and professionals may believe the failure is intentional or the result of laziness or low intelligence. Over time, a youth with LD may integrate these explanations, compounding their propensity towards low self-esteem, depression, truancy, and dropping out of school. Furthermore, if one focuses solely on a youth's behaviors or failures, the learning disabilities may be overlooked.

Among students with identified learning disabilities, 35 percent drop out of high school, a rate twice that of peers without disabilities (LDA, 1996). School dropout is a significant risk factor in later juvenile delinquency. Among youth with LD, 62 percent of those who dropped out of school were arrested within three to five years; among those who did graduate, the arrest rate was 15 percent (Wagner, 1992).

The persistent failure can lead to a lack of confidence and self-esteem as well as behavioral problems. In order to "fit in" with their peer group, youth with LD may more readily yield to peer pressure, even when aware that the behavior is wrong. Language deficits have been linked to inadequate problem-solving skills, diminished moral reasoning, and lack of understanding of consequences in these youth (Brier, 1989). Overall, youth with LD experience low self-esteem, have difficulty anticipating consequences for their actions, and are prone to suggestibility, less flexible and at a higher risk for acting out behaviors (Waldie & Spreen, 1993).

Working with Youth Who Have Learning Disabilities

If a youth is a first-time offender involved with juvenile court, a screening for learning disabilities would ensure the youth is accorded appropriate accommodations for participating in the justice process and also has access to disability-specific correctional programming.

Those working with a youth with LD can assist the youth in organizing his or her thoughts, perhaps by tape recording or having him or her write down a chronology of events and review it.

The impact of LD on understanding spoken language is of particular concern for a youth accused of committing a crime. For example, a youth with LD may not adequately understand the concept of Miranda rights. The Miranda rights are a list of constitutional rights, including the right to be represented by an attorney, that is read to persons at the time they are arrested. Studies show that a majority of individuals do not understand what it means to "waive your rights" when the Miranda warning is read, even if the statement is adapted into elementary language (Shepherd & Zaremba, 1995).

In addition, a youth with learning disabilities may not be able to relate his or her story logically, consistently answer questions correctly, or follow instructions. These inconsistencies may result in police officers, juvenile intake personnel, attorneys, and other court personnel believing the youth is being uncooperative or is lying (LDA, 1996). Those working with a youth with LD can assist the youth in organizing his or her thoughts, perhaps by tape recording or having him or her write down a chronology of events and review it.

Most youth with learning disabilities overcome their challenges and become successful, personally and professionally. To promote success in youth with LD, professionals who work with them need to consider the following:

- Prescreening youth for LD assessments early in justice processes. Many youth with LD are misdiagnosed or not diagnosed;
- Determining the need for vocational, technical, and functional skills assessment;
- Developing a comprehensive and appropriate special education, vocational and counseling program, if necessary (Spekman, 1993);
- Making referrals to agencies serving youth with LD and their families;
- Assisting youth in understanding and accepting their disability, and helping them learn how to be proactive, how to set realistic goals, and how to persevere in getting their needs met and reaching goals (Spekman, 1993); and
- Mentoring relationships that are supportive, directive, and understanding of the LD.

Developmental Disabilities (DD)

The category of developmental disabilities (DD) comprises severe, chronic disabilities attributed to mental or physical impairments or combinations of mental and physical impairments with onset before age 22. These disabilities are likely to continue indefinitely and result in substantial functional limitations in three or more areas of major life activity. They also are likely to result in the need for a combination of special, interdisciplinary, or generic care, treatment, or other services which are lifelong or extended and are individually planned and coordinated (IDEA, 1997).

Mental retardation and **autism** are two examples of developmental disabilities present among youth in the juvenile justice system. Some youth with mental retardation may also have ADHD or conduct disorder. Youth with autism may also exhibit impulsivity, aggressiveness, short attention span, and obsessional behaviors. (Conley, et al., 1992; *DSM-IV*, 1994; Noble & Conley, 1992)

It is difficult to determine how many persons with developmental disabilities enter the justice system. The prevalence of mental retardation in the prison population is 12.6 percent (Leone, 1991). The presence of a developmental disability may not be detected if aggressive behaviors, mental illness, substance abuse, seizure disorders, or speech, hearing or communication difficulties are more apparent; individuals with DD may thus not be identified by law enforcement officers or other professionals as having a disability (McGee & Menolascino, 1992). Furthermore, adolescents may be unlikely or unwilling to acknowledge their disability.

Certain characteristics of developmental disabilities may lead a youth to confess to a crime because he or she wants to please adults and believes that is what the authorities want to hear. Also, youth with DD are more likely to be convicted of the offense rather than of a reduced charge (Lustig, 1995).

Characteristics of developmental disabilities in a suspected juvenile offender include:

- Smiling inappropriately during interrogation
- An inability to understand or answer questions, so responses do not seem to make sense
- Difficulty in being understood because of extremely limited verbal ability or a speech impairment

- Overly eager to please authorities with responses, even when those responses sound unreasonable
- Difficulty with simple tasks such as telling time, reading and writing, or using the telephone or a telephone book (Adapted from The Arc, from *Defendants, Victims and Witnesses with Mental Retardation.*)

Mental Retardation

The most common developmental disability, mental retardation (MR), affects 3 percent of the general population (NICHCY, 1991). A 1990 analysis estimated that 12.6 percent of incarcerated youth qualified for a diagnosis of MR (Leone et al., 1991).

A youth with mental retardation is significantly below average in intellectual functioning and has coexisting limitations in two or more of these skill areas:

- Communication
- Self-care
- Home living
- Social skills
- Community use
- Self-direction
- Personal health and safety
- Academics, leisure, and employment

Three unique risks for youth with mental retardation to become involved in unlawful behaviors include:

- **Peer influence.** A youth with MR may be more easily influenced, and therefore more vulnerable to being exploited by an experienced criminal. Typically, they are an accomplice to a crime rather than the initiator.
- **Low self-esteem.** The involvement of a youth with MR in a crime committed with others may stem from the youth's need to feel personal connections with others, especially those without apparent disabilities. The youth may be seeking reinforcement of his or her need to be seen "like everyone else," rather than as a person with a disability.
- **Lack of a comprehensive understanding** of illegal activities and their subsequent consequences (Wood & White, 1992).

Most offenses committed by a youth with DD tend to be nonviolent crimes or misdemeanors (Reynolds, 1995). Serious offenders with DD are often immature and impulsive and have severely impaired judgment and ability to manage their anger. They are vulnerable to victimization by people close to them through abuse or manipulation. Offenders with DD who commit more serious and aggressive crimes are often dually diagnosed with mental health disorders (Brady & Jefferson, 1996).

Because of their typically low self-esteem, youth with DD may be drawn to anyone who will "befriend" them. The "friendships" and excitement of risky behaviors are tempting for a vulnerable, eager-to-please youth. Similarly, youth with DD may be recruited by more experienced criminals, who recognize that the person most likely to be caught in a crime is the more vulnerable "accomplice" rather than themselves. They may assume that youth with DD will not be credible witnesses and may be unable to convincingly identify a ringleader.

Offenders with DD who commit more serious and aggressive crimes are often dually-diagnosed with mental health disorders.

Autism

Autism may be manifested in a number of behaviors and with varying degrees of severity. A youth with autism often has difficulty with expressive and nonverbal language, comprehension skills, language processing, and social and interactive skills. He or she may have difficulty making eye contact or expressing emotions in a typical manner; may exhibit repetitive behaviors, such as rocking, hand wringing, or pacing; and may not be able to focus well on one task (*DSM-IV*, 1994).

According to the *DSM-IV* (1994), the essential features of autism include "impaired development in social interaction and communication and a markedly restricted repertoire of activities and interests. . . . There may be marked impairment in the use of nonverbal behaviors (e.g., eye-to-eye gaze, facial expression, body postures and gestures) to regulate social interaction and communication." (66)

There may be monotonous, impaired or repetitive speech, or a disturbance in the comprehension of speech. Children with autistic disorder may have short attention span, impulsivity, aggressiveness, and self-injurious behaviors.

IDEA (1997) defines autism as "a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age 3, that adversely affects a child's educational performance."

To someone unfamiliar with these behaviors, a youth with autism may appear to be lacking in remorse or to be indifferent to the crime he or she is accused of committing. A youth's lack of typical expressiveness may suggest a guilty demeanor to some, when in fact they may be anxious or emotionally disconnected from the events going on around them.

Working with Youth Who Have Developmental Disabilities

If a youth with developmental disabilities becomes involved in the justice system, it is important that someone who knows the youth or is knowledgeable about DD is present. However, efforts to identify a youth with DD in the justice system are not generally reliable or systematic (Brier, 1989). In fact, at the earliest stages of the criminal justice process, it is highly unlikely a youth will be properly identified as having DD (Conley et al., 1992).

Assumptions may be made that the youth understands the charges or understands the implications of confessing to a crime, or that his or her behavior indicates a lack of remorse.

Questions regarding accurate identification of a developmental disability are critical because they have implications for the individual's competence to understand criminal charges, participate in his or her own defense, and stand trial or have his or her sentence appealed. Assumptions may be made that he or she understands the charges or understands the implications of confessing to a crime, or that his or her behavior indicates a lack of remorse. The competency standard relates to whether an individual understands the charges and can participate in his or her own defense. These assumptions can affect any decisions regarding determination of the youth's competency to stand trial.

It is only recently that educators, parents, and health and social service professionals have focused on the need for youth with developmental disabilities to learn about risky behaviors and assertiveness skills. Correctional goals should include opportunities for consistent, repeated instruction and role-play exercises regarding vulnerability, illegal behaviors, and risky relationships.

In *Residential Facilities for Juvenile Offenders* (1995), Minnesota's Legislative Auditor's evaluation acknowledges the lack of specialized services for offenders with developmental disabilities, as well as for those offenders with both DD and aggressive sexual behaviors. In most correctional facilities, persons with mental retardation are expected to follow the same rules and regulations as others. Their inability to comply because of cognitive differences makes it more challenging for them to earn privileges and, ultimately, an early parole.

Because of their need to be accepted, youth with developmental disabilities may be likely to integrate the negative values in prison culture (Santamour, 1986). Furthermore, they are uniquely vulnerable to victimization and sexual abuse within many correctional settings (Pranis, 1991; Santamour, 1986). Because of their cognitive differences, they may rely on aggressive behavior as a means of self-defense or may be unable to meet the conditions for early parole (Smith & Algozzine, 1990). In addition, they have more difficulty participating in the development of a release plan, and often serve longer sentences than other offenders for the same offense (Lustig, 1995).

Conversely, professionals are concerned with the apparent lack of meaningful correctional options available when serious criminal cases against people with developmental disabilities are dropped due to their inability to understand the charges or to participate in their own defense. Often these cases involve assaultive or violent behaviors. The absence of any consequences may be disappointing for the victim as well as ineffective for the potential rehabilitation of the offender.

Post-release programs and services designed specifically for youth with DD are rare. Once released, youth with developmental disabilities have few options in appropriate probation programs, such as group homes, therapeutic foster care, or mental health and substance abuse programs. They often have limited work skills, and they may have developed or intensified antisocial behaviors while in prison. Without appropriate activities, employment, and a transition plan back into the community, the likelihood that they will reoffend is high (Leone, 1990). Like all young offenders, youth with DD need ongoing supports in school, in the community, and within the family to effectively reinforce acceptable behaviors.

A standard series of questions, considered at the time of arrest, interrogation or sentencing, will help ensure that a youth with developmental disabilities is identified and afforded due process, and that his or her disability addressed in disposition. These questions include:

1. Should a disability professional be consulted?
2. If a youth has cognitive or communication impairments or both, has someone who knows his or her communication patterns been consulted?
3. Does the youth understand the relationship between the behaviors that led to the arrest and the consequences considered or imposed?
4. Are there programs better able to accommodate the youth's disability and possible vulnerability?

5. Is the youth currently receiving special education and mental health services? Does he or she have an IEP? If not, is an evaluation or assessment needed?
6. Are the proposed consequences likely to be meaningful to the youth, considering his or her disability?

Correctional and probation programming for youth with developmental disabilities should focus on:

- Training and employment opportunities
- Development of functional, cognitive, and social assets
- Self-awareness
- Healthy sexuality
- Identifying vulnerabilities and learning self-protection strategies
- Self-image and self-esteem
- Assisted living residences and/or independent living skills
- Promotion of typical developmental milestones

Probation services for a youth with developmental disabilities should emphasize close supervision and attainment of functional and job skills. Substance abuse and mental health treatment programs, if needed, should be adapted to the disability of the youth. Also, correctional alternatives to incarceration should be considered for a youth with DD who has aggressive behaviors.

Options include programs that involve the family, group homes, therapeutic foster placements and separate programs for persons with developmental disabilities within correctional facilities. All correctional program staff need adequate training on working with youth who have DD. Overall, a youth with DD needs a combination of services or supports that is lifelong and individually planned and coordinated (Laski, 1992; Morton, et al., 1986; Wood & White, 1992).

Communication Difficulties Confronted by Individuals with Mental Retardation

People with mental retardation face a number of communication difficulties, all of which negatively affect their rights in the judicial process. The following is a list of some of these difficulties:

A. **An Eagerness to Please** – Individuals with mental retardation do not communicate on an "equal footing." They are eager to please others and are often unusually accommodating, especially to those persons they view as being in positions of authority (police, attorneys, judges).

B. **Concrete Thinking Patterns** – Individuals with mental retardation are unable to engage in abstract thinking. They think only concretely. For example: When asked if he wishes to waive his rights to have an attorney present before talking to police, an individual with mental retardation may be concretely focused on waving his right hand as opposed to waving his left hand.

C. **Communication Through Mimicking** – Individuals with mental retardation often learn to do things the "right" way by copying others. They learn to communicate by affirming the choice that is suggested last.

D. **Communication Through Protectors** – Individuals with mental retardation learn to communicate through the "voice" of a protector. In the hands of the wrong "protector," instead of friendship there is domination, and the person with retardation can engage in crime at another's behest.

E. **Communication Through Bluffing Greater Understanding** – Individuals with mental retardation often seek to mask their disability, trying to pass for "normal."

F. **Communication Through a Pleasant Facade** – Individuals with mental retardation learn that smiling is one way to gain approval or to have their needs met. The problem that arises is that they do not know when their smiling is inappropriate.

G. **Problems with Receptive and Expressive Language** – The most common communication difficulty is the problem that individuals with mental retardation have in expressing themselves, usually because of intellectual deficits (illiteracy). They may not be receptive to the ordinary flow of spoken language, requiring that they be spoken to more slowly and clearly.

H. **Limited Memory/Impaired Recall** – Even when individuals with mental retardation can verbalize effectively, their ability to remember and recall events may be impaired. This is particularly true of events that the individual has not deemed to be important.

I. **Impulsivity/Short-Attention Span** – Individuals with mental retardation are often described as having poor impulse control. This characteristic is related to difficulties with attention span and focus.

Questions to Ask If You Suspect a Defendant Has Mental Retardation

1. Was the individual classified in school for special education?
2. Has the individual ever held a steady job?
3. Does the individual have a driver's license?
4. How does the individual support himself?
5. Does the individual receive any financial assistance such as Supplemental Security Income (SSI)?
6. Does the individual appear to understand the questions being asked?
7. Does the individual respond to questions without unnecessary delay?
8. Does the individual have an eagerness to please others?
9. Can the individual explain his or her actions in his or her own words?

"Communication Difficulties. . ." and "Questions If You Suspect. . ." are from *Defendants with Mental Retardation: A Guide for Attorneys*, produced by the Developmentally Disabled Offenders Program, The Arc of New Jersey, 1996. Adapted with permission from Suzanne Lustig, Director of the Developmentally Disabled Offenders Program.

42

Case Study: Ben

"Ben" is a 15-year-old African American with mental retardation who lives with his mother in an inner-city neighborhood. Ben's mother, Jessie, also has mental retardation as well as depression. Jessie has worked steadily for eight years and is very devoted to her son.

Ben fits none of the stereotypes that exist about mental retardation. He doesn't look "different," he likes sports and knows the names of his favorite players, and he always has a few girlfriends. Kids at school know that Ben is "slow." They don't hang out with him, but they're not deliberately unkind to him. Until he got into trouble with the law, Ben would have been described as "gentle," an unlikely person to act violently.

Someone approached Ben in the neighborhood to have some fun together, maybe smoke some pot and hang out. It was an irresistible invitation for him, since this was someone older and known as a "cool" guy. So they shared a joint and then went out to find a dealer with more drugs to sell. Ben was there when his "friend" got into a car driven by someone else, traded some drugs and money, exchanged some words with the driver, and shot him. Ben didn't know the gun was real. In fact, at first he thought it was a joke. He knew he should not have had marijuana, but he couldn't believe that someone would actually shoot another person for apparently no reason.

When the police brought him into the precinct for questioning, Ben giggled, grinned, and paced the room. To the police, Ben didn't appear to have a conscience. "He appears to have no remorse," stated the police report. There was no attorney present at the police interview. The police did not know that Ben has an IQ of 65 or that, although he had the keys in his pocket, he did not know how to start the car. Ben was booked as an accessory in the murder as well as for possession of drugs.

Fortunately, Ben was assigned a knowledgeable public defender that quickly raised pertinent questions regarding Ben's competency. She argued successfully for a reduced charge. Ben was sent to a correctional facility for six months, where he was continually harassed by other boys for being "slow." Much of his time was spent watching television. Ben's county social worker describes him now as truant, aggressive, and highly vulnerable to being exploited again.

Chapter II

Entitlements for Youth with Disabilities in the Justice System: Individuals with Disabilities Education Act (IDEA)

Many youth who have been placed in juvenile facilities have not had successful educational experiences. Some have diagnosed disabilities. Others have had ongoing difficulty with school behavior or academic performance, but have not been evaluated to determine if they have a disability. Both groups have a need to reach or maintain a level of academic skill that will permit, when their sentence ends, a successful transition back to their home schools and communities. Both groups may potentially be eligible for special education services in their correctional placement.

The Individuals with Disabilities Education Act (IDEA), as amended in 1997, is an educational entitlement act for youth with disabilities ages three through twenty-one. IDEA requires the provision of a free, appropriate public education (FAPE) to qualified youth, and provides them and their parents with specific due process rights.

An Individualized Education Program (IEP), based on an evaluation of educational needs, is developed for each young person found eligible for special education and related services. The IEP is developed by a team that includes educators, providers, and the youth and his or her parent(s).

Special education and related services must be provided wherever young people live or attend school, including in facilities such as schools, alternative learning centers, treatment centers, group homes, camps, and juvenile or adult correctional programs.

States may assign the responsibility for educating juveniles who are convicted as adults and serving time in adult prisons to any public agency deemed appropriate by the governor. Services must be provided in accordance with state standards and must include an appropriate elementary or secondary education curriculum.

While most correctional facilities typically offer standard educational and vocational programs for youth, such services are often not consistent with federal and state requirements for youth with disabilities.

Special education under IDEA means "Specially designed instruction, at no cost to parents, to meet the unique needs of a child with a disability, including (a) instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings; and (b) instruction in physical education." Special education services include:

- individualized academic instruction
- physical education
- accommodations
- anger management and conflict resolution skills
- social skills training
- work readiness skills or work experience
- independent living skills training
- any other area where there is a need for specialized instruction

Related services include transportation and such developmental, corrective, and other supportive services as may be required to assist a child with a disability to benefit from special education. Specific related services include, but are not limited to:

- speech-language pathology and audiology services
- psychological services
- physical and occupational therapy
- recreation, including therapeutic recreation
- social work services
- counseling services, including rehabilitation counseling
- early identification and assessment
- orientation and mobility services
- medical services for diagnostic and evaluation purposes
- school health services and social work services in school
- parent counseling and training

Mental Health Services

Mental health services, such as individual or group counseling provided by a school psychologist, social worker, or counselor, are "related services" for students with disabilities when they need such services to benefit from their special education programs.

Most correctional facilities do not provide necessary health and mental health services, even when those services are part of a current IEP, according to the Office of Juvenile Justice and Delinquency Prevention. This is in direct violation of IDEA, Section 504 of the Rehabilitation Act, and state law.

Special Education and Related Services in Correctional Settings

The LEA in which the correction facility is located (or other agency designated by the State Education Agency) is responsible for educating juveniles with disabilities who are incarcerated. In Minnesota, for example, the Department of Corrections has been designated as the LEA (school district) responsible for providing special education and related services when youth are placed in correctional settings that operate their own educational programs.

Special education and related services must be provided by appropriately licensed personnel, such as special education teachers, psychologists, social workers, counselors, or licensed mental health professionals.

Exceptions to IDEA

An exception to the obligation to evaluate and serve eligible youth was added in the 1997 Amendments to IDEA. States may elect not to provide special education and related services to youth ages 18 through 21 who are *convicted as adults* and incarcerated in adult prisons, if, in their most recent educational placement prior to incarceration, they were not identified as having a disability, and did not have an IEP. This exception does *not* apply to youth who had been identified and received services through an IEP but dropped out of school prior to incarceration.

A correctional IEP team may also modify an individual's IEP for a bona fide security or compelling penological interest *that cannot otherwise be accommodated.*

Multidisciplinary Evaluation

School districts and other designated agencies are responsible for conducting a *multidisciplinary evaluation* to determine whether a young person needs special education and related services as a result of having a disability. If a youth has not been identified as disabled at the time of placement but has behaviors that suggest he or she may have a disability and need special education, an evaluation should be initiated as soon as possible.

School districts and other responsible agencies have an obligation under IDEA to locate, identify, and evaluate youth suspected of having a disability and needing special education services. Parents, attorneys, judges, or other involved persons may request an evaluation. Many correctional facilities will arrange with their local school district or the district in which the youth's parents reside to conduct this evaluation. Subsequent reevaluations may be completed whenever conditions warrant, or at the request of a parent or teacher, but at least once every three years.

Parent Permission for Evaluation

An educational evaluation or reevaluation of a young person under the age of 18 requires that a parent, surrogate parent, or legal guardian provide written consent before the evaluation takes place. Such consent must be "informed," which means that the person giving consent must understand why the evaluation or reevaluation is needed and what specific tests are being proposed. If a public agency has taken steps to secure parent permission for a reevaluation (letter to home, visit to workplace, etc.) and has not received a response from the parents within a specified timeline (usually 10 days), the agency may proceed with the reevaluation.

If a child is a ward of the state or if the parents cannot be located, a *surrogate parent* must be appointed by the school district or agency to represent the youth's interests for the purpose of special education planning. Young persons over the age of 18 may assume the role of "parent" for the purpose of granting consent for their own evaluation.

Purpose of the Evaluation

A team of persons, which may include a psychologist, teacher, therapist, educational diagnostician, or other person will complete the evaluation to determine if a youth is a "child with a disability" under IDEA, and to determine what kinds of services will be needed. Responsible agencies must ensure that evaluation will not discriminate on a racial or cultural basis. The evaluation must be provided at no cost to the family, even when it includes medical or mental health examinations.

The term "child with a disability" under IDEA means a child who has a disability and, because of the disability, needs special education and related services. The determination that a youth qualifies for services, and the kinds of services the youth needs, cannot be based on a single test or instrument.

An evaluation must be in all areas of suspected need. For some youth with severe behavior problems, an evaluation might include an assessment of academic skills to determine whether the behaviors of concern are related to frustration with learning.

If a youth is found eligible for special education and related services, the results of evaluation will be used to develop an IEP.

The IEP Team

An IEP is developed by a team that includes:

- the student's parent(s)
- the regular education teacher of the student
- the special education teacher of the student
- a representative of the school district qualified to provide or supervise special education services and who is knowledgeable about the general curriculum
- the student
- other individuals with expertise in the student's needs

Both the young person and his or her parent(s) should help develop the goals and objectives. If a youth is over 18 and the parents have not retained guardianship (more common for youth with severe disabilities), the youth may legally act as his or her own "parent" in developing the IEP and agreeing or disagreeing with the proposed services.

The IEP Document

This written document will include the special education, related services, and accommodations needed by a youth with a disability to make appropriate school progress. The IEP includes statements of:

- present levels of educational performance
- measurable annual goals and short-term objectives or bench marks
- special education and related services and supplementary aids and services
- the extent to which youth will *not* participate in regular classes and activities
- modifications in state- or districtwide assessments; if such assessments are not appropriate, how the youth will be alternatively assessed (Participation in these assessments does not apply for youth *convicted as adults* and serving time in adult prisons.)
- projected date for beginning special education and related services and modifications, and their anticipated frequency, location, and duration
- how progress towards the annual goals will be measured
- how parents will be regularly informed (at least as often as parents are informed of nondisabled children's progress) of progress toward the goals and if progress is sufficient to attain the goals by the end of the year
- beginning at age 14 and annually thereafter, the transition service needs of a youth
- beginning at age 16 (or earlier), statements of needed transition services
- at least one year before the age of majority, a statement in the IEP that the youth has been informed of rights that transfer to him or her at the age of majority

In addition to the required components just listed, there are a number of additional considerations made by the IEP team that have importance for youth in correctional facilities. Several required considerations are:

- the strengths of the youth and concerns of the parent for enhancing his or her education
- the results of the initial or most recent evaluation
- the use of positive behavior interventions, strategies, and support for youth whose behaviors impede their learning or that of others
- the language needs as they relate to the IEP for youth with limited English proficiency
- whether a youth needs an assistive technology device and services

Ensuring IEP Continuity in a Correctional Setting

If a young person already has a current IEP upon entering a correctional facility, the IEP may be implemented as it is written. If modifications are needed to reflect the change in placement from a school-based to a correctional program, an IEP team should be convened to discuss and make necessary changes.

Historically, one of the difficulties in providing services has been that correctional facilities may not have adequate information about the needs of a young person entering the facility. Even if they are asked, some youth will not acknowledge that they were receiving special education services. Additionally, records may not always be readily available.

Access to Previous School Records

A request for transfer of school records should be initiated as soon as possible following placement. If families move frequently or if youth have been placed out of their family home prior to incarceration, their records may have become lost or mislaid during transfers. *Public agencies must continue to provide a free, appropriate public education to identified youth, even if records are misplaced or are missing.* At times, a public agency may need to develop an "interim" plan for services, based on telephone conversations with the school district and with the youth and parents, while records are being located or a reevaluation is being completed.

Each state must have policies in place to ensure that a free, appropriate public education is provided to eligible students. In Minnesota, it is the legal responsibility of the agency providing educational services to request a youth's records from the previous school setting. School district staff or parents may make special education information available in writing to the director of a correctional facility to ensure that services continue in the new placement.

Standards for how and under what circumstances disciplinary and special education records are transmitted to agencies other than those responsible for providing special education and related services are covered under the Family Educational Rights and Privacy Act (FERPA).

Special Education Services for Youth "Dropouts"

For youth who have dropped out of school before being sent to a correctional placement, it will be important to review the records of the last educational placement to determine whether the youth was receiving special education services at the time of leaving school. If so, a determination needs to be made about whether the student has a current IEP (written within the past year), whether the evaluation is current (within the past three years), and whether a new evaluation is needed.

Truancy and *dropout* are both closely tied to juvenile criminal behavior and to chronic school problems. By addressing student needs through special education in a structured setting, it may be possible for many youth to acquire needed skills.

Services During Case Disposition or Placement Planning

A student remains in his or her current educational placement during case disposition or placement, unless he or she has been removed from school. If the youth is detained in a facility while awaiting disposition, educational services must be provided consistent with an IEP. If that is not possible for compelling security or penological reasons, then services that approximate the current IEP as closely as possible must be provided. If changes are needed, a meeting must be arranged as soon as possible with the IEP team.

Planning for Transitions Back to the Home School

Planning for the transition between a correctional placement and the youth's home school district should begin well in advance of release to ensure there is no break in educational programming. The youth and his or her parents must be involved in determining the appropriate home school environment and the supports that will be needed.

An IEP planning meeting for this important transition should examine the environments and curriculum in the school to which a youth will be returning, and develop services to meet any projected academic, social, or work-related needs.

It is important to gather a record of the credits earned in the correctional setting so that the youth does not have to repeat classes that have already been completed. In developing a new IEP for return to a school setting, teachers, parents, and the youth should discuss reasonable school expectations.

In residential settings, rules are usually clear and consistent. In schools, however, the variety of learning environments and differing adult expectations can result in an enormous amount of stress on youth. Many youth who have been successful in a structured correctional environment have returned to their schools to find themselves unable to meet the behavioral expectations. Some may not be able to meet routine timelines for handing in classwork or have the same control in self-managing behaviors as was true in the correctional setting. Ensuring that accommodations are available is a key part of transition planning for youth returning to their schools from a correctional setting.

School Discipline

Schools frequently have one standard for punishing all students regardless of the limitations of a youth or circumstances surrounding a behavior. When a youth is unable to adhere to the discipline standards established for all students in a school, the IEP team should consider an individualized behavior support plan as part of the IEP or Section 504 plan.

The emphasis in such a plan should be on using appropriate positive interventions to support behavioral development and ensure that consequences for unacceptable behavior are reasonable for the particular youth. The simplistic-sounding "catch them being good" phrase is actually an excellent intervention strategy for reinforcing appropriate behaviors.

Punishment is popular because it often works immediately to halt inappropriate behavior, at least for a short time. However, stopping a behavior for a brief period of time is not the same as teaching youth what to do instead of using the behavior.

For students who have unacceptable behaviors, a free and appropriate public education includes a duty to address the *cause* of the inappropriate behaviors. Building self-esteem and self-confidence means providing high-quality instruction with support services designed to address other needs that impede the ability to reach standards expected for all students.

When a Youth Cannot Follow Standard Discipline Policies

Most reasonable people would agree that rules must be for everyone. However, for some people, following simple rules (remembering to have materials on hand for class, controlling one's temper) is difficult or impossible because of the nature of their disabilities.

If the IEP team agrees that a student cannot consistently meet a behavioral expectation or benefit from the standard consequences for noncompliance, the team must develop alternative consequences for that youth. The idea is not to allow a youth to escape consequences for actions, but to ensure that the misbehaviors are within the control of the youth, and that the consequences are reasonable and instructive.

Examples of Potential Discrimination

Following are some simple examples of how rules that are intended for all may inadvertently discriminate against certain youth with disabilities:

- Denying credit to students whose absences exceed the maximum permitted by a district, when those absences are related to a disability. For example, a student with severe depression or anxiety may not be able to come to school regularly for a time when the disability is not well managed.
- Requiring a specific grade point average for a student to play in intramural or varsity sports, if the student's team determines that the student is simply not able to meet the requirement. Some students with learning disabilities or emotional disorders may never meet grade expectations in regular classes without significant accommodations in the general curriculum.
- Suspension from school for irritating but not dangerous behaviors that are simply poor behavioral habits. While suspensions are an emergency removal that may be necessary, removals do not teach students to become more reflective or less impulsive. Some behaviors are a result of impulsivity, or are unconsciously performed, such as tapping a pencil or humming. Some are nonvolitional; that is, they are not within the realm of behavioral control—such as tics for a student with Tourette syndrome, or the physiological effects of some medications. Still others are calculated and planned either to escape (avoid) something a youth does not want to do, or to gain something (such as peer attention).

Understanding the origins of behavior is important in developing a planned response to the behavior. Increasingly, youth are being referred to the court systems for behaviors that are a manifestation of their disabilities. Frequently, those behaviors are not addressed constructively at the local school district level before a student is referred to the justice system. In one study, 50 percent of first time offenders were found to have previously unidentified learning disabilities (LDA, 1996).

At times, students with a history of severe disruptive behaviors have been inappropriately expelled from their schools without being evaluated for learning, cognitive, or emotional disorders. Students with disorders such as just described might have responded well to an instructive, nonpunitive educational program.

Making a Manifestation Determination

If a special education student has been suspended from his or her school program for more than 10 school days in a school year, the IEP team must meet to determine whether the behaviors resulting in such removals are a manifestation of the youth's disability. This is true whether that program is delivered in a public school or in a correctional setting.

Consideration must be given to any medical, psychological, or psychiatric reports that will assist in making the manifestation determination. The team must consider the needs of the youth and determine whether those needs are being appropriately addressed in the current educational program. They must also determine whether the youth was able to understand the impact and consequence of the behavior, and whether the youth had the ability to control the behavior. Such determination is based on data—not how someone personally feels about the behavior, but whether data exist to support the belief. For instance, a youth with a history of chronic, disruptive behavior, who because of the behavior is identified as emotionally disturbed, is a youth for whom behavior is likely a clear manifestation of disability.

If the behaviors are determined to be a *manifestation of a disability*, the IEP team will develop an instructional plan as an alternative to continuing removals, to teach acceptable alternative behaviors. Section 504 of the Rehabilitation Act of 1973 is a federal law that specifically prohibits discrimination based on disability.

Functional Behavioral Assessment

If youth are suspended, expelled, or otherwise removed from their educational programs for more than 10 days, the IEP team is required to meet to develop a plan for a functional behavioral assessment (FBA), or to review a positive intervention plan if one has been written. Although FBA is required if a youth has been removed for more than 10 days, it should be considered whenever an IEP team has questions about why a specific behavior occurs.

FBA is a process for collecting data to help a team to understand why problem behaviors occur. Functional assessment collects information about events in the environment and how behaviors are reinforced or shaped by their environment.

The evaluator will examine the quality of interpersonal relationships, the number of students, the "fit" between student and teacher, the appropriateness of the curriculum, etc., to determine the qualities of environments that sustain positive behaviors, as well as the characteristics that support negative behaviors. Through this process of collecting data to understand where and under what circumstances negative behaviors occur, the evaluator attempts to answer the question "Why is the behavior occurring?"

If it is possible to understand the conditions that led to or reinforced negative behavior, an IEP team can develop strategies to modify the environment to be more conducive to learning.

An example of a positive approach to teaching pro social behavior skills is a behavior plan that permits a youth to leave a classroom without consequence when he or she is becoming angry or anxious, and to report to a predetermined place until calm. This process is proactive because the intervention is used *before* the behaviors occur, and empowering because the responsibility for making the decision rests with the youth. Teaching youth how to manage their own behaviors so that they can be successful in the world is, of course, one of the responsibilities of a correctional placement. The services and due process procedures of IDEA have been designed to provide youth with disabilities access to appropriate learning experiences.

Parent Rights When Schools Refuse to Make Accommodations

Schools are required to modify or amend where necessary any part of the school discipline plan to accommodate a student's disability. A due process complaint to the Office of Monitoring of a state may be made by parents under IDEA when schools or school personnel refuse to make necessary accommodations to their curriculum, codes of conduct, etc.

Section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of disability, is another avenue for complaint. An allegation that an educational program has discriminated against a student on the basis of disability can be filed with the regional Office for Civil Rights.

Resolving Disagreements

IDEA has established procedures for resolving disagreements between parents and educators when they arise. Parents have the right to disagree with any program or services they do not believe meets their child's needs. Such disagreements may be resolved in one of several ways:

1. **Mediation**: an informal conference with a trained, objective third party who attempts to help resolve the concerns between parents and the school district or responsible agency. The mediator is not a decision-maker. Schools and other agencies are required to offer mediation to parents who request a due process hearing to resolve issues.
2. **Due Process Hearing**: a formal dispute resolution process established in IDEA. Usually a due process hearing is requested when less formal methods have not been successful. Either a parent or a school district may request a due process hearing. An impartial due process hearing officer will preside over the hearing and issue a decision, which is binding upon both parties. If either parents or schools are not satisfied with the decision of the hearing officer, the decision may be appealed. In Minnesota, appeals are directed to the State Commissioner of Children, Families, and Learning.
3. **Complaint**: A complaint is an allegation that a school district is not in compliance with established special education law. Complaints may be submitted to the state's Office of Monitoring, to be investigated by a complaint officer. A corrective order will be issued if the complaint officer substantiates the issues stated in the complaint.

Section 504 of the Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 is a broader federal law than IDEA. It applies to any agency under which a youth might receive services, not just schools. Section 504 states:

"No qualified person with a disability shall, on the basis of disability, be excluded participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives benefits from federal financial assistance (34 CFR 104.3{a})."

A "qualified individual with a disability" under Section 504 is one who:

- has a physical or mental impairment which substantially limits one or more major life activities (caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working);
- has a record of such impairment; or
- is regarded as having such impairment.

After an evaluation has been completed to determine the impact of the disability on learning, a youth may be eligible under Section 504 for accommodations in the regular education setting or for placement in a setting that meets his or her needs. A Section 504 team can be convened for a student with a disability who does not meet IDEA criteria for services, if the disability significantly affects learning.

A Section 504 plan or accommodations plan is of particular importance for youth who have diagnoses such as learning disabilities, ADHD, depression, or other mental health disorders. Related services, such as mental health counseling, may be required under a Section 504 plan, even if the youth is not eligible for special education and related services under IDEA, if the services are necessary so as not to discriminate against the youth. A school district is responsible for implementing any accommodations the team determines necessary.

Both the IEP and the Section 504 plan specify the instruction and related services that a youth is to receive, regardless of where education is provided.

Chapter III

Promoting Family Involvement

Most studies confirm that maintaining family ties while youth are incarcerated and establishing positive family relationships correlate with a successful transition back into the community, and ultimately, with reduced recidivism.

Most studies confirm that maintaining family ties while youth are incarcerated and establishing or preserving positive family relationships correlate with a successful transition back into the community, and ultimately, with reduced recidivism (Dague & Tolin, 1996). Yet, according to one report (*Residential Facilities*, 1995), most surveys of correctional staff indicate that not enough is done to involve families.

Families often have a wealth of information about the youth that is important to professionals as they work with the youth throughout the justice process. This information, particularly as it relates to a youth's strengths and needs, can be valuable when justice and corrections personnel are making assessment decisions, programming and placement determinations and aftercare and transition plans. Also, the family is likely to be a part of the youth's life long after the role of justice professionals has ceased and can have an impact on the youth's future success.

Family involvement in the justice process can promote positive, long term outcomes for the youth and family, including:

1. The youth and family members will have made an investment in correctional planning and may feel ownership and commitment to follow through.
2. The youth and family members learn how to respond to situations and behaviors and how to resolve conflicts.
3. Family members maintain or strengthen their relationship with the youth, facilitating a successful transition home.

In order to participate meaningfully in juvenile justice processes, families of youth with disabilities need information about the juvenile justice system and how the system works, and their youth's rights to special education services and disability-specific accommodations. However, there are limited opportunities for families and professionals to effectively share valuable information about the youth in the juvenile justice system.

One process that does exist in which parental participation is required is in planning for a youth's special education program. Under IDEA, parents of students with disabilities, both in and out of the juvenile justice system, have the right to participate in decisions about their students' education. (See Chapter II.)

Despite the importance of, and legal requirement for, family participation in special education planning, families of youth in the justice system generally are underinvolved at all stages of the judicial process. Some things professionals can do to involve families include:

Under IDEA, parents of students with disabilities, both in and out of the juvenile justice system, have the right to participate in decisions about their students' education.

- Consult regularly and positively with families about the needs and progress of their youth who have been incarcerated. Parents have legal rights regarding educational planning for their children with disabilities. Also, involving parents in their youth's correctional program increases the likelihood of a successful transition back into the community for the youth.
- Consider the use of new technologies, such as telephone conferencing, to assist families in being informed and involved with their youth while in a correctional placement. Family attendance at meetings may not be possible due to lack of transportation, distance from home to the facility, cost of the trip, nontraditional work schedules, illness, disability, or child care issues. In addition, a youth's phone privileges may be restricted and, if the youth has communication disabilities, use of the telephone may be a challenge. A case manager, probation officer, social worker, counselor, or other corrections staff may assist a family in overcoming these barriers.
- Youth who are wards of the state, or whose parents cannot be located, are legally entitled to a surrogate parent to act on their behalf in the area of special education program planning. The youth can benefit from the involvement of an advocate who cares about the youth and his or her educational program within the correctional setting.
- Family members of youth with disabilities in the justice system need access to, and regular progress reports on, all medical, mental health, and educational services their youth receives.
- Aftercare program planning with family, schools, corrections, and social services should begin well before a youth returns to the community, and coordination of the plan needs to be continued and monitored upon a youth's return to the community.

Parents may feel that because of their youth's alleged criminal behavior, they too are being judged by the school, the court and the community. For some parents, especially those who have disabilities similar to their youth's, the youth's negative school experiences may mirror their own. Parents who may have experienced negative interactions with schools and service systems may be hesitant to work with some professionals. Other parents may simply have no experience working with professionals, may not know how to proceed, or may become overwhelmed by the complexity of the system. Professionals can reach out to underinvolved families in the following ways:

1. Encourage parents to learn all they can about their youth's disability and what it might mean for the entire family. Refer them to a disability resource such as PACER Center in Minnesota or other parent centers (see list in Appendix) and encourage parent-to-parent contacts as sources of support and information.
2. Regard families as the experts they usually are by listening and acknowledging their insights about their youth, their experiences, and their feelings.
3. Consider families as allies in meeting the needs of the youth within a challenging system.
4. Avoid prejudgments of families and sincerely attempt to establish effective working relationships with them.
5. Develop an understanding of the distinct cultural behaviors of each family. Non-minority professionals may misperceive the behaviors of a culturally or racially diverse family. Seek cultural competency training and resources, if necessary.
6. Support parents in learning and applying consistent, appropriate discipline techniques that take into consideration the youth's disability.
7. Model and encourage parents to reinforce the youth's positive behaviors and accomplishments.
8. Encourage parents to be involved with and monitor their youth's activities and friends.
9. Facilitate parental involvement in their youth's education planning and help parents understand the importance of continuing involvement with schools as a way to model commitment to education for their youth.
10. Model and assist parents in learning how to work with educators, service providers, and other professionals in setting goals and resolving issues related to their youth.

11. Provide information and resources regarding the juvenile justice adjudication process to parents, guardians, or surrogates in language they can understand.
12. Include information about court procedures, terminology, and timelines; the roles of families and professionals throughout the process; the legal rights of the youth and his or her parents, including their rights to special education services and appeals processes; judicial standards regarding competency; and referrals to advocacy, disability, medical and counseling providers.

Recommendations for More Hopeful Responses

1. Rehabilitation, treatment, and functional, vocational, and academic skill competencies should remain primary goals in developing appropriate consequences for youth in the juvenile justice system.
2. Depending on a youth's disability, he or she may benefit from a correctional and probationary approach that incorporates the concepts of restorative justice. That is, community-based efforts that bring offender and victim together to explore accountability, mediation, and reparations.
3. Develop, implement, and monitor a consistent screening process including:
    - A checklist for attorneys to assist them in prescreening youth for possible assessments;
    - An assessment tool that will be used statewide to identify young offenders in need of more comprehensive evaluations and possible special education services. This tool should incorporate self-reports and information from parents, educators and other people familiar with the youth.

Chapter IV

Systems and Services: Looking to More Hopeful Responses

"Everything about juvenile crime is harder to manage now. In the last week alone I've tried to find placement for three older teenagers with mental health problems and developmental delays. They mainly were in trouble because of stealing and drinking. But they're aggressive, so it's harder to find any placement that will take them, let alone one that has special programs. Sometimes insurance won't pay for what they need. It would be great if we could order a comprehensive assessment or work out a special treatment program in the community, but it's not realistic. There are not a lot of people out there to look out for these kids. That's why they get in trouble again and again."

There is a need for justice processes and correctional alternatives that meet the unique needs of youth, including disability-specific, mental health, racial, cultural and gender considerations.

The social worker who expressed this frustration was accurate in her comments on the challenges in working with complex cases in the juvenile justice system. Many professionals across disciplines share her feelings.

In large part, the difficulties stem from attempting to respond to competing and equally valid goals:

- The obligation to protect public safety
- The requirement to allocate punishment according to a prescribed legal standard
- The historic mandate of the juvenile court for rehabilitation
- The federal obligation of providing special education to those youth that qualify for services

Barriers exist within the juvenile justice system that make it more difficult for youth with disabilities to receive appropriate and meaningful correctional responses.

Additionally, the juvenile justice system has become more punitive than rehabilitative. Youth accused of minor offenses, youth who are inappropriately charged for behaviors that are characteristics of their disability, are facing potential sanctions far more severe than is appropriate.

System and Service Problems in Juvenile Justice Systems

Youth with disabilities face significant challenges in the juvenile justice system:

Inadequate Identification and Assessment of Disability Needs

1. The lack of disability-specific information among attorneys, probation officers, judges, and other personnel, including information regarding federal mandates for youth with disabilities.
2. The need for common, consistent, and culturally appropriate evaluation, assessment, and testing standards for identifying disabilities in youth in the corrections system.
3. A need for court procedures that involve families or family surrogates from the time a youth is charged until he or she completes sentencing and probation.
4. A comprehensive response to first-time youthful offenders, including disability, mental health, and other psychosocial assessments.
5. Greater acknowledgment of the impact of a disability as a factor in juvenile crime and recidivism.

Difficulties in Matching Offenders with Consequences and Placements That Can Effectively Address Their Disability Needs

1. Court procedures and correctional alternatives that meet the unique needs of youth, including disability-specific, mental health, racial, cultural, and gender considerations.
2. No precedent for monitoring, evaluating, and reporting information about programmatic strengths, successes, and outcomes in public and for-profit correctional placements.
3. Logistic, practical, and financial barriers to including families of offenders in the rehabilitative process when youth are placed out of the home.
4. Integration of a standard of appropriate educational and functional skill attainment in correctional programs that meet state educational objectives.

The Absence of Strong Aftercare Programs and Transition Planning for Youth Leaving the Corrections Setting

1. Comprehensive, integrated, and individualized aftercare programs, including formal and informal community supports to youth and their families.

2. Transition planning for returning to the home and community initiated well before a youth is released. This includes greater involvement with the youth's home school district in developing educational plans that promote strengths and skills.

Promising Models

Earlier chapters have identified the common and often interrelated risk factors for delinquent and criminal behavior. They include the presence of one or more emotional, behavioral, or learning disabilities; school failure; family violence; a history of family mental illness; poverty; early antisocial behaviors; and others.

While the origins of juvenile delinquency and criminal behavior are well documented, less is known about long-term effective prevention strategies and especially consequences for delinquent and criminal behaviors.

Components of Successful Programs

Programs that seem to be more successful in reducing criminal behavior are those that

- Involve and integrate the multiple systems and services in the youth's life. These can include the family (or surrogate), the special education case manager, probation officer, mental health professional, community members, the faith community, and friends.
- Offer specialized approaches to youth with emotional and behavioral disorders, substance abuse, and other contributing conditions.
- Provide positive educational resources that include small classes, individualized instruction, and supportive peer interaction.
- Offer highly focused goal-oriented structured therapy.
- Provide training in improving critical-thinking skills for high-risk youth.
- Teach daily living skills.
- Address juvenile offenders' known risk factors.
- Help parents to understand disruptive behaviors and advocate for greater supervision and positive behavioral supports.
- Provide a range of mental health, and skill-based training. (Adapted from Sherman, et al., 1998.)

Restorative Justice

One of the initiatives that shows promise and hope for youth, families, and communities struggling with crime and delinquency is the Restorative Justice Approach, also known as the Balanced Approach. The goals of this approach are:

- to ensure accountability for illegal behavior,
- to assist the offender to develop those competencies that could prevent re-offending; and
- to protect public safety.

Currently, when a crime is committed, an offender may be charged, tried, and sentenced (often months after the crime has been committed) without ever facing his or her victim. The state is responsible for determining consequences, and the victim is not included in the process. Moreover, offenders must only deal with the court. They do not directly confront their victims or learn the impact of their behavior in a meaningful or timely way.

The restorative justice model addresses the impact of criminal behavior directly on the victim and the community. Offenders must face their victims, acknowledge the harm, and make tangible amends for the damage they have caused.

For many youth with impulsive behaviors, poor memory, difficulty with cognitive processes, and other disability issues, it is especially important that the impact of their behaviors and the consequences are both *understood* and *quickly resolved*. The Restorative Justice process may be able to accomplish the Approach goals for these particular youth.

The Principles of Restorative Justice

1. Criminal behavior is harmful to communities, victims, and offenders.
2. Implicit in criminal behavior is the responsibility to make amends.
3. The offender must acknowledge responsibility for the criminal behavior and repair the harm.
4. The victim must have a major role in determining what is needed to repair the harm.
5. Restitution to the victim and the community becomes the primary goal.
6. The community must assume some responsibility for those conditions that contribute to the criminal act.

7. A criminal act becomes personalized, because it is no longer a crime perpetrated against the state but against an individual or the community.
8. Effectiveness is not determined by the amount of punishment, but, rather, by whether adequate compensation was made. (Center for Restorative Justice and Medication, School of Social Work, 1996)

Application of the Restorative Justice Model

Restorative justice models can be individually adapted and include different individuals according to unique circumstances in each case. Some examples of how this approach can be applied include:

1. Interventions are adapted to meet specific needs of offenders with disabilities so they are better able to gain insight about the impact of their behavior.
2. Offenders undertake projects identified by the community. These can include cleaning graffiti from public areas, working in shelters, painting homes of senior citizens, clearing trash, and other neighborhood improvement projects.
3. Community members assist in job training and reintegration into the community once the offender demonstrates a willingness to meet his or her obligations.
4. Mediation programs in elementary grades teach young children more acceptable means of dealing with conflict. In Minnesota, these programs have significantly reduced the number of suspensions (Smetanka, 1996).
5. Sentencing projects based on Native American circle models, or other types of culturally specific consequences.
6. The faith community can become involved in the process by helping offenders to find spiritual links.
7. Trained facilitators work with offenders and victims in programs called "Family Group Conferencing" or "Victim Offender Mediation."

Results from studies of restorative justice are encouraging, especially when comparing re-offense rates. According to the Center for Restorative Justice and Mediation, "Fewer and less serious crimes were committed within one year following victim offender mediation. . . . Juvenile offenders who participated in victim offender mediation felt mediation was not easier than other types of punishment such as incarceration or probation. Juvenile offenders felt they were held accountable for their crime." (1996)

Recommendations for More Hopeful Responses

1. Rehabilitation; treatment; and functional, vocational, and academic skill competencies should remain primary goals in developing appropriate consequences for youth in the juvenile justice system.
2. Depending on a youth's disability, he or she may benefit from a correctional and probationary approach that incorporates the concepts contained in new models such as restorative justice or multisystemic therapy.
3. Develop, implement, and monitor a consistent screening process that includes:
   - A checklist for attorneys to assist them in prescreening youth for possible assessments;
   - Assessment tools that will be used statewide to identify young offenders in need of more comprehensive evaluations and possible special education services. This tool should incorporate self-reports and information from parents, educators, and others familiar with the youth.
4. Develop and implement an integrated interagency process for information sharing, in accordance with data privacy standards, so that recommendations and decisions are based on a comprehensive, shared understanding of the individual.
5. If children have multiple placements, examine what failed for that child—and try and implement some change in future planning.
6. Examine county, state, and federal funding streams and initiate cost-comparisons with other approaches and models for dealing with juvenile violence and crime.
7. Before a case comes to trial, or after a youth is sentenced, there may be a significant time lag before he or she is remanded to a setting for the duration of their sentence. In some cases, a youth may move from one setting to another and a youth with disabilities may be without special education services for an extended (and legally out of compliance) period of time. Services should follow the youth.
8. A procedure should be integrated into the trial process that enables parents, surrogates, or other advocates for an adjudicated youth to formally provide information about the youth's disability, his or her special education needs, and other disability-specific accommodations that have been successful.
9. More diversion and correctional programs should be developed to keep youth with disabilities in settings that are small, highly structured, treatment-oriented, and well supervised.

10. Information about the juvenile justice adjudication process should be provided to parents, guardians, or surrogates.

11. The state and counties should develop a database of programs that are successful for young offenders. Information about the strengths and weaknesses of these programs, based on program evaluations, would be made available to case managers, probation officers, attorneys, judges, and social workers.

12. Correctional programs should develop comprehensive, integrated aftercare programs for offenders when they leave a correctional program and reenter the community, with information and support to a youth's family, school, and vocational setting.

13. Ongoing training should be mandatory for professionals (including attorneys, judges, and probation officers) regarding the characteristics of the disabilities most common in young offenders, how to determine whether special education services are warranted, and how to identify those correctional programs that might be most effective for youth with disabilities.

14. Foster care providers of therapeutic programming and staff working in correctional programs with youth who have disabilities should receive preservice and inservice disability training.

15. Provide federal and state funding to Parent Training and Information Centers and Community Parent Resource Centers to educate parents about the juvenile justice system. Additionally, families of youth in the juvenile justice system should be made aware of resources such as Parent Training and Information Centers and disability law centers in each state that could assist them in understanding and acquiring the services to which their child with a disability is entitled. Advocates knowledgeable in both educational and juvenile justice systems should be hired to assist families supporting their youth across systems. This should include information about accessing an appeals process for special education services through the Department of Corrections or Department of Education.

16. Communities should encourage and develop partnerships between the public and private sectors to provide employment, skills training, and volunteer opportunities for youth with disabilities.

17. Cultural competency training should be strengthened and included in orientation of all staff who work with culturally and racially diverse youth, including staff in law enforcement, corrections settings, probation, social work, and the legal profession.

18. Develop and implement a comprehensive crime prevention program targeting youths with disabilities engaged in at-risk behaviors or early criminal involvement. Ideally, this program should be implemented before middle school. Strategies include addressing parent training needs; improving communication with parents and educators; meeting special education needs (where appropriate); and increasing functional vocational, academic and social skills.

19. Developing conflict resolution and problem-solving skills and skills that promote insight and accountability.

20. State departments of education and corrections might consider creating an appointed director of special education position to oversee all state- and county-administered correctional facilities and residential treatment facilities. The director would be responsible for providing staff training on special education law, for monitoring and compliance, and for promoting the development of educational, psychosocial, and vocational services to meet the needs of offenders with disabilities.

Conclusion

Youthful offenders bring a unique set of needs into the justice system. Moreover, youth with disabilities have needs requiring even more specialized approaches. Historically, a mission of the juvenile justice system was to ensure that youth were judged in an environment that recognized and considered a youth's unique culpability and rights. Rehabilitation of the youthful offender was considered an inviolable goal of correctional consequences. However, as the number and severity of youth crimes increased, the system mandate has shifted toward punitive approaches. These have been shown to be largely ineffective. In fact, studies indicate that harsh penalties actually increase the likelihood for criminals to re-offend as well as commit crimes of a more serious nature (Cannon, 1997).

There is no one formula for developing effective correctional approaches and consequences to reduce youth crime and recidivism.

As yet, there is no *one* formula for developing effective correctional approaches and consequences to reduce youth crime and recidivism. The interrelation of a range of potential risk factors may impact a youth's attainment of emotional health, prosocial skills, positive educational experiences and life skill competencies. The disability itself is one unique risk factor, particularly if it has not been identified early and has not been addressed with effective interventions. Coupled with poverty, abuse and neglect, and other risks, the impact of a disability on a youth's opportunities for success is compounded.

For youth with disabilities, IDEA and ADA ensure that those who qualify are entitled to special education in correctional programming and disability-specific accommodations in justice processes. Furthermore, multisystemic approaches in corrections can bring families and multidisciplinary professionals together to address each youth's unique strengths and needs.

It is not necessary, nor feasible, for all persons working with youth in the justice system to become proficient in disability identification and accommodation. However, with increased awareness about disabilities and risk factors common among juvenile offenders, professionals will be better able to contribute to more meaningful outcomes for the offender. For more information on these and other disabilities, see the Appendix for a list of Minnesota and national disability organizations or contact PACER Center.

Appendix

Resource List of National Organizations Related to Youth and Juvenile Justice

American Bar Association
Center on Children & the Law
740 Fifteenth St. NW, 9th Floor
Washington, DC 20005
Tel: 202-662-1720
Fax: 202-662-1755
ctrchildlaw@abanet.org
www.abanet.org/child/

Bureau of Justice Assistance Clearinghouse
P.O. Box 6000
Rockville, MD 20850
Toll-free: 800-688-4252
askbja@ojp.usdoj.gov
www.ojp.usdoj.gov/BJA/

Bureau of Justice Statistics Clearinghouse
P.O. Box 6000
Rockville, MD 20850
Toll-free: 800-723-3277
askbja@ojp.usdoj.gov
www.ojp.usdoj.gov/bjs/

CDC Youth Violence Evaluation Project
Youth Violence & Prevention Team
National Center for Injury Prevention & Control
4770 Buford Highway NE, MS K-60
Atlanta, GA 30341-3724
Tel: 770-488-4646
www.cdc.gov/ncipc/dvp/yvpt/yvpt.htm

Center for the Study & Prevention of Violence
Institute of Behavioral Science
University of Colorado at Boulder
Campus Box 442
Boulder, CO 80309-0442
Tel: 303-492-8465
Fax: 303-443-3297
cspv@colorado.edu
www.colorado.edu/cspv/

Children's Defense Fund
25 E St. NW
Washington, DC 20001
Tel: 202-628-8787
cdfinfo@childrensdefense.org
www.childrensdefense.org

Child Welfare League of America
440 First St. NW, 3rd Floor
Washington, DC 20001
Tel: 202-638-2952
Fax: 202-638-4004
webweaver@cwla.org
www.cwla.org

Coalition for Juvenile Justice
1211 Connecticut Ave. NW, Suite 414
Washington, DC 20036
Tel: 202-467-0864
Fax: 202-887-0738
juvjustice@aol.com
www.nassembly.org/html/mem-cjj.html

Family Violence Prevention Fund
383 Rhode Island St., Suite 304
San Francisco, CA 94103
Tel: 415-252-8900
Fax: 415-252-8991
fund@fvpf.org
www.fvpf.org

Juvenile Justice Clearinghouse
P.O. Box 6000
Rockville, MD 20849-6000
Fax: 301-519-5212
Toll-free: 800-638-8736
askncjrs@ncjrs.org
www.ncjrs.org

Juvenile Law Center
801 Arch St., Suite 610
Philadelphia, PA 19107
Tel: 215-625-0551
Fax: 215-625-9589
HN2403@handsnet.org
www.jlc.org

National Center for Juvenile Justice
710 Fifth Ave., Suite 3000
Pittsburgh, PA 15219-3000
Tel: 412-227-6950
Fax: 412-227-6955
ncjj@ncjj.org
www.ncjj.org

National Center for Youth Law
114 Sansome St., Suite 900
San Francisco, CA 94104
Tel: 415-543-3307
Fax: 415-956-9024
info@youthlaw.org
www.youthlaw.org

National Child Welfare Services Resource Center on Legal & Court Issues
740 Fifteenth St. NW, 9th Floor
Washington, DC 20005
Tel: 202-662-1720
www.abanet.org/child/

National Clearinghouse on Families & Youth
P.O. Box 13505
Silver Spring, MD 20911-3505
TTY & Tel: 301-608-8098
Fax: 301-608-8721
www.ncfy.com

National Council on Crime & Delinquency
685 Market St., Suite 620
San Francisco, CA 94105
Tel: 415-896-6223
Fax: 415-896-5109
nccd@hooked.net

National Crime Prevention Council
1700 K St. NW, 2nd Floor
Washington, DC 20006-3817
Tel: 202-466-6272
Fax: 202-296-1356
webmaster@ncpc.org
www.ncpc.org

National Criminal Justice Reference Service
P.O. Box 6000
Rockville, MD 20849-6000
Tel: 301-519-5500
Toll-free: 800-851-3420
Toll-free TTY: 877-712-9279
askncjrs@ncjrs.org
www.ncjrs.org/ncjhome.htm

National Juvenile Detention Association
Three Hundred One Perkins Building
Richmond, KY 40475
Tel: 606-622-6259
njdaeku@aol.com
www.njda.com

National School Safety Center
141 Duesenberg Dr., Suite 11
Westlake Village, CA 91362
Tel: 805-373-9977
Fax: 805-373-9277
info@nssc1.org
www.nssc1.org

Office of Juvenile Justice & Delinquency Prevention
810 Seventh St. NW
Washington, DC 20531
Tel: 202-307-5911
Fax: 202-307-2093
askjj@ojp.usdoj.gov
www.ncjrs.org/ojjhome.htm

PACER Center
4826 Chicago Ave. S.
Minneapolis, MN 55417-1098
Tel: 612-827-2966
TTY: 612-827-7770
Fax: 612-827-3065
Toll-free in MN: 800-537-2237
pacer@pacer.org
www.pacer.org

Prevent Child Abuse America
(formerly National Comittee to Prevent Child Abuse)
200 Michigan Ave., 17th Floor
Chicago, IL 60604-2404
Tel: 312-663-3520
Fax: 312-939-8962
mailbox@preventchildąbuse.org
www.childabuse.org

Street Law, Inc.
(formerly National Institute for Citizen Education in the Law)
1600 K St. NW, Suite 602
Washington, DC 20006
Tel: 202-293 0088
Fax: 202-293-0089
www.streetlaw.org

U.S Department of Justice
950 Pennsylvania Ave. NW
Washington, DC 20530-0001
ADA Information Line
Toll-free: 800-514-0301
Toll-free TTY: 800-514-0383
web@usdoj.gov
www.usdoj.gov

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Parent Training and Information Centers

The following is a list of the Parent Training and Information Centers (PTIs) that serve families of children and adults with disabilities throughout the U.S. The list is accurate as of this writing; however, the information does change frequently. For updates on any of the PTIs, call PACER or visit PACER's Web site (*www.pacer.org*).

Alabama

Special Education Action Committee, Inc.
Carol Blades
P.O. Box 161274
Mobile, AL 36616-2274
TDD & Tel: 334-478-1208
Fax: 334-473-7877
Toll-free in AL: 800-222-7322
seacofmobile@zebra.net
www.hsv.tis.net/~seachsv/

Alaska

PARENTS, Inc.
Faye Nieto
4743 E. Northern Lights Blvd.
Anchorage, AK 99508
TDD & Tel: 907-337-7678
Fax: 907-337-7671
Toll-free in AZ: 800-478-7678
parents@parentsinc.org
www.alaska.net/~parents/

American Samoa

American Samoa P.A.V.E.
Fa' Anati Penitusi
P.O. Box 3432
Pago Pago, AS 96799
Tel: 011-684-699-6946
Fax: 011-684-699-6952
SAMPAVE@samoatelco.com
www.taalliance.org/ptis/amsamoa/

Arizona

RAISING Special Kids
Mary Slaughter
4750 N. Black Canyon Highway, Suite 101
Phoenix, AZ 85017-3621
TDD & Tel: 602-242-4366
Fax: 602-242-4306
Toll-free in AZ: 800-237-3007

Pilot Parents of Southern Arizona
Lynn Kallis
2600 N. Wyatt Dr.
Tucson, AZ 85712
Tel: 520-324-3150
Fax: 520-324-3129
PPSA@azstarnet.com
www.azstarnet.com/~ppsa/

Families Reaching Harmony, Inc.
Thedia Michelle Gamble
PTI serving Native Americans
P. O. Box 5423
Window Rock, AZ 86515
Tel: 520-729-2468
Fax: 520-729-2470
TMGenigma@aol.com

Arkansas

Arkansas Disability Coalition
Wanda Stovall
1123 University Ave., Suite 225
Little Rock, AR 72204-1605
TDD & Tel: 501-614-7020
Fax: 501-614-9082
Toll-free in AR: 800-223-1330
adc@alltel.net
Statewide
(With FOCUS AR)

FOCUS, Inc.
Ramona Hodges
305 W. Jefferson Ave.
Jonesboro, AR 72401
Tel: 870-935-2750
Fax: 870-931-3755
Toll-free: 888-247-3755
focusinc@ipa.net
(With Arkansas Disability Coalition AR)

California

DREDF
Diane Lipton
2212 Sixth St.
Berkeley, CA 94710
TTY & Tel: 510-644-2555
Fax: 510-841-8645
Toll-free: 800-466-4232
dredf@dredf.org
www.dredf.org
Northern California
(With Matrix and Parents Helping Parents, Santa Clara)

Exceptional Family Support, Education, & Advocacy Center
Debbie Rowell
6402 Skyway
Paradise, CA 95969
Tel: 530-876-8321
Fax: 530-876-0346
Toll-free: 800-750-1101
sea@sunset.net
www.sea-center.org

Exceptional Parents Unlimited
Leslie Lee
4120 N. 1st St.
Fresno, CA 93726
Tel: 559-229-2000
Fax: 559-229-2956
epu1@cybergate.com
Central California

Loving Your Disabled Child (CPRC*)
Theresa Cooper
4528 Crenshaw Blvd.
Los Angeles, CA 90043
Tel: 323-299-2925
Fax: 323-299-4373
lydc@pacbell.net

Matrix
Deidre Hayden
94 Galli Dr., Suite C
Novato, CA 94949
Tel: 415-884-3535
TDD: 415-884-3554
Fax: 415-884-3555
matrix@matrixparents.org
www.matrixparents.org
Northern California
(With DREDF and Parents Helping Parents, Santa Clara)

***(CPRC)=Community Parent Resource Center**

Parents Helping Parents of San Francisco
Lois Jones
594 Monterey Blvd.
San Francisco, CA 94127-2416
Tel: 415-841-8820
Fax: 415-841-8824
Nine counties in the San Francisco Bay area

Parents Helping Parents of Santa Clara
Mary Ellen Peterson
3041 Olcott St.
Santa Clara, CA 95054-3222
Tel: 408-727-5775
TDD: 408-727-7655
Fax: 408-727-0182
info@php.com
www.php.com
Northern California
(With Matrix and DREDF)

Support for Families of Children with Disabilities
Juno Duenas
2601 Mission, Suite 710
San Francisco, CA 94110-3111
Tel: 415-282-7494
Fax: 415-282-1226
sfcdmiss@aol.com
San Francisco

TASK
Joan Tellefsen
100 W. Cerritos Ave.
Anaheim, CA 92805
Tel: 714-533-8275
Fax: 714-533-2533
taskca@aol.com
Southern California

TASK, San Diego
Gus Licht
3750 Convoy St., Suite 303
San Diego, CA 92111-3741
Tel: 619-874-2386
Fax: 619-874-2375
tasksd1@aol.com
City of San Diego and Imperial counties

Colorado

PEAK Parent Center, Inc.
Barbara Buswell/Judy Martz
6055 Lehman Dr., Suite 101
Colorado Springs, CO 80918
Tel: 719-531-9400
TDD: 719-531-9403
Fax: 719-531-9452
Toll-free: 800-284-0251
info@peakparent.org
www.peakparent.org

Connecticut

Connecticut Parent Advocacy Center, Inc.
Nancy Prescott
338 Main St.
Niantic, CT 06357
TDD & Tel: 860-739-3089
Fax: 860-739-7460 (Call first to dedicate line)
Toll-free in CT: 800-445-2722
cpacinc@aol.com
members.aol.com/cpacinc/cpac.htm

Delaware

Parent Information Center of Delaware, Inc.
Marie-Anne Aghazadian
700 Barksdale Rd., Suite 3
Newark, DE 19711
Tel: 302-366-0152
TDD: 302-366-0178
Fax: 302-366-0276
picofdel@aol.com
members.aol.com/PICofDEL

District of Columbia

Advocates for Justice & Education, Inc.
Bethann West
2041 Martin Luther King Ave. SE, Suite 301
Washington, DC 20020
Tel: 202-678-8060
Fax: 202-678-8062
Toll-free: 888-327-8060
justice1@bellatlantic.net
www.aje.qpg.com/
Temporarily serving Wards 1–5 of the District of Columbia

DC Parent Training & Information Center
Holly Easterday Adams
817 Varnum St. NE
Washington, DC 20017
Tel: 202-832-6860
Fax: 202-636-2996
Temporarily serving the Washington DC area

Florida

Family Network on Disabilities
Jan LaBelle
2735 Whitney Rd.
Clearwater, FL 33760-1610
Tel: 813-523-1130
Fax: 813-523-8687
Toll-free in FL: 800-825-5736
fnd@fndfl.org
fndfl.org

Parent to Parent of Miami, Inc. (CPRC)
Janet Bell Taylor
c/o Sunrise Community
9040 Sunset Dr., Suite G
Miami, FL 33173
Tel: 305-271-9797
Fax: 305-271-6628
PtoP1086@aol.com
Miami, Dade, and Monroe Counties

Georgia

PEPPAC
Linda Shepard
6613 E. Church St., Suite 100
Douglasville, GA 30134
Tel: 770-577-7771
Fax: 770-577-7774
peppac@bellsouth.net
www.peppac.org

Hawaii

AWARE
Jennifer Schember-Lang
200 N. Vineyard Blvd., Suite 310
Honolulu, HI 96817
Tel: 808-536-9684
TTY: 808-536-2280
Fax: 808-537-6780
ldah@gte.net

Idaho

Idaho Parents Unlimited, Inc.
Cheryl Fisher
4696 Overland Rd., Suite 568
Boise, ID 83705
TDD & Tel: 208-342-5884
Fax: 208-342-1408
Toll-free: 800-242-4785
ipul@rmci.net
home.rmci.net/ipul

Illinois

Designs for Change
Donald Moore/Miguel Jimanez
Six N. Michigan Ave., Suite 1600
Chicago, IL 60602
Tel: 312-857-9292
TDD: 312-857-1013
Fax: 312-857-9299
Toll-free: 800-851-8728
dfc1@aol.com

Family Resource Center on Disabilities
Charlotte Des Jardins
20 E. Jackson Blvd., Room 300
Chicago, IL 60604
Tel: 312-939-3513
TDD: 312-939-3519
Fax: 312-939-7297
Toll-free in IL: 800-952-4199
frcdptiil@ameritech.net
www.ameritech.net/users/frcdptiil/index.html

Family T.I.E.S. Network
Deb Kunz
830 S. Spring
Springfield, IL 62704
Tel: 217-544-5809
Fax: 217-544-6018
Toll-free: 800-865-7842
ftiesn@aol.com
www.taalliance.org/ptis/fties/
Central and Southern Illinois

National Center for Latinos with Disabilities
Maria Elena Rodriguez-Sullivan
1921 S. Blue Island Ave.
Chicago, IL 60608
Tel: 312-666-3393
TTY: 312-666-1788
Fax: 312-666-1787
Toll-free: 800-532-3393
ncld@ncld.com
homepage.interaccess.com/~ncld/

Indiana

IN*SOURCE
Richard Burden
809 N. Michigan St.
South Bend, IN 46601-1036
Tel: 219-234-7101
TDD: 219-239-7575
Fax: 219-234-7279
Toll-free in IN: 800-332-4433
insourc1@aol.com
home1.gte.net/insource/

Iowa

Parent Training & Information Center of Iowa
Jule Reynolds
3015 Merle Hay Rd., Suite 6
Des Moines, IA 50310-1270
Tel: 515-251-7323
TTY: 515-278-0571
Fax: 515-270-4602
Toll-free: 800-450-8667
HN5317@earthlink.net
www.taalliance.org/ptis/ia/

Kansas

Families Together, Inc.
Connie Zienkewicz
3340 W. Douglas, Suite 102
Wichita, KS 67203
Tel: 316-945-7747
TTY in Wichita: 316-945-7747
Fax: 316-945-7795
Toll-free in KS: 888-815-6364
fmin@feist.com
www.kansas.net/~family/

Kentucky

Family Training & Information Center
Paulette Logsdon
2210 Goldsmith Ln., Suite 118
Louisville, KY 40218
Tel: 502-456-0923
Fax: 502-456-0893
Toll-free: 800-525-7746
FamilyTrng@aol.com

Louisiana

Pyramid Parent Training Program (CPRC)
Ursula Markey
P.O. Box 51837
New Orleans, LA 70151
Tel: 504-895-5970
Fax: 504-899-5739
Dmarkey404@aol.com

Project PROMPT
Leah Knight
4323 Division St., Suite 110
Metairie, LA 70002-3179
Tel: 504-888-9111
Fax: 504-888-0246
Toll-free: 800-766-7736
fhfgno@ix.netcom.com
www.projectprompt.com

Maine

Special Needs Parent Info Network
Janice LaChance
Maine Parent Federation, Inc.
P.O. Box 2067
Augusta, ME 04338-2067
Tel: 207-582-2504
Fax: 207-582-3638
Toll-free in ME: 800-870-7746
parentconnect@mpf.org
www.mpf.org

Maryland

Parents Place of Maryland, Inc.
Josie Thomas
7484 Candlewood Rd., Suite S
Hanover, MD 21076-1306
TDD & Tel: 410-859-5300
Fax: 410-859-5301
info@ppmd.org
www.somerset.net/ParentsPlace/

Massachusetts

Federation for Children with Special Needs
Richard Robison
1135 Tremont St., Suite 420
Boston, MA 02120-2140
TTY & Tel: 617-236-7210
Fax: 617-572-2094
Toll-free in MA: 800-331-0688
fcsninfo@fcsn.org
www.fcsn.org/

Michigan

CAUSE
Patrick Strong
3303 W. Saginaw, Suite F-1
Lansing, MI 48917-2303
TDD & Tel: 517-886-9167
Fax: 517-886-9775
Toll-free in MI: 800-221-9105
info-cause@voyager.net
www.pathwaynet.com/cause/

Parents Are Experts, Wayne County
Jessie Mullins
23077 Greenfield Rd., Suite 205
Southfield, MI 48075-3745
TDD & Tel: 248-557-0070
Fax: 248-557-4456
Toll-free: 800-827-4843
ucp@ameritech.net
www.taalliance.org/ptis/mi-parents/

Minnesota

PACER Center, Inc.
Paula Goldberg/Virginia Richardson
4826 Chicago Ave. S.
Minneapolis, MN 55417-1098
Tel: 612-827-2966
TTY: 612-827-7770
Fax: 612-827-3065
Toll-free in MN: 800-537-2237
pacer@pacer.org
www.pacer.org

Mississippi

Parent Partners
Aretha Lee
1900 N. State St., Suite C-100
Jackson, MS 39216
TTY & Tel: 601-366-5707
Fax: 601-362-7361
Toll-free in MS: 800-366-5707
ptiofms@misnet.com
www.taalliance.org/ptis/ms/

Project Empower (CPRC)
Agnes Johnson
136 S. Poplar Ave.
Greenville, MS 38701
Tel: 601-332-4852
Fax: 601-332-1622
Toll-free: 800-337-4852

Missouri

Missouri Parents Act
Sonia Moran
2100 S. Brentwood, Suite G
Springfield, MO 65804
Tel: 417-882-7434
Fax: 417-882-8413
Toll-free in MO: 800-743-7634
mpac01@MCIONE.com
www.crn.org/mpact/

Montana

Parents, Let's Unite for Kids
Katharin Kelker
516 N. 32nd St.
Billings, MT 59101-6003
TTD & Tel: 406-255-0540
Fax: 406-255-0523
Toll-free in MT: 800-222-7585
plukinfo@pluk.org
www.pluk.org

Nebraska

Nebraska Parents Center
Glenda Davis
1941 S. 42nd St., Suite122
Omaha, NE 68105-2942
TDD & Tel: 402-346-0525
Fax: 402-346-5253
Toll-free: 800-284-8520
gdavis@neparentcenter.org
www.neparentcenter.org

Nevada

Nevada Parents Encouraging Parents, Inc.
Karen Taycher
601 S. Rancho Dr., Suite C25
Las Vegas, NV 89106
Tel: 702-388-8899
Fax: 702-388-2966
Toll-free in NV: 800-216-5188
nvpep@vegas.infi.net
mh102.infi.net/~nvpep/

New Hampshire

Parent Information Center
Judith Raskin
P.O. Box 2405
Concord, NH 03302-2405
TDD & Tel: 603-224-7005
Fax: 603-224-4365
Toll-free in NH: 800-232-0986
picnh@aol.com
www.taalliance.org/ptis/nhpic/

New Jersey

Statewide Parent Advocacy Network
Diana MTK Autin
35 Halsey St., 4th Floor
Newark, NJ 07102
Tel: 973-642-8100
Fax: 973-642-8080
Toll-free: 800-654-7726
span@bellatlantic.net
www.taalliance.org/ptis/nj/

New Mexico

EPICS Project
Martha J. Gorospe
P.O. Box 788
Bernalillo, NM 87004
Tel: 505-867-3396
Fax: 505-867-3398
Toll-free: 800-765-7320
epics@highfiber.com
Parents of Indian Children with Special Needs nationwide

Parents Reaching Out, Project ADOBE
Larry Fuller
1000 A Main St. NW
Los Lunas, NM 87031
TDD & Tel: 505-865-3700
Fax: 505-865-3737
Toll-free in NM: 800-524-5176
nmproth@aol.com
www.parentsreachingout.org

New York

The Advocacy Center
Colin Garwood
277 Alexander St., Suite 500
Rochester, NY 14607
TDD & Tel: 716-546-1700
Fax: 716-546-7069
Toll-free in NY: 800-650-4967
info@advocacycenter.com
www.advocacycenter.com

Advocates for Children of NY
Ana Espada
105 Court St., Suite 402
Brooklyn, NY 11201
Tel: 718-624-8450
Fax: 718-624-1260
advocat1@idt.com
Five boroughs of New York City

Parent Network Center
Joan Watkins
250 Delaware Ave., Suite 3
Buffalo, NY 14202
Tel: 716-853-1570
TDD: 716-853-1573
Fax: 716-853-1574
Toll-free in NY: 800-724-7408
info@parentnetworknys.org
www.parentnetworknys.org
Statewide except in New York City

Resources for Children with Special Needs
Karen Schlesinger
200 Park Ave. S., Suite 816
New York, NY 10003
Tel: 212-677-4650
Fax: 212-254-4070
resourcesnyc@prodigy.net
New York City

Sinergia
Myrta Cuadra
15 W. 65th St., 6th Floor
New York, NY 10023
Tel: 212-496-1300
Fax: 212-496-5608
Sinergia@panix.com
www.sinergia.org
New York City

United We Stand (CPRC)
Lourdes Rivera-Putz
c/o Casa del Barrio
728 Driggs Ave.
Brooklyn, NY 11211
Tel: 718-302-4313, ext. 562
Fax: 718-302-4315
uwsofny@aol.com
www.taalliance.org/ptis/uws/

North Carolina

ECAC, Inc.
Connie Hawkins
P.O. Box 16
Davidson, NC 28036
Tel: 704-892-1321
Fax: 704-892-5028 (Call first to dedicate line)
Toll-free in NC: 800-962-6817
ECAC1@aol.com

North Dakota

Pathfinder Family Center
Kathryn Erickson
ArrowHead Center
1600 Second Ave. SW
Minot, ND 58703
Tel: 701-852-9426
TDD: 701-852-9436
Fax: 701-838-9324
Toll-free in ND: 800-245-5840
ndpath01@minot.ndak.net
www.ndcd.org/pathfinder/

Ohio

Child Advocacy Center
Cathy Heizman
1821 Summit Rd., Suite 303
Cincinnati, OH 45237
Tel: 513-821-2400
Fax: 513-821-2442
CADCenter@aol.com
Southwestern Ohio, Northern Kentucky, and Dearborn County, Indiana

OCECD
Margaret Burley
Bank One Building
165 W. Center St., Suite 302
Marion, OH 43302-3741
Tel: 740-382-5452
Fax: 740-383-6421
Toll-free in OH: 800-374-2806
ocecd@gte.net
www.taalliance.org/PTIs/regohio/

Oklahoma

Parents Reaching Out in OK
Sharon Bishop
1917 S. Harvard Ave.
Oklahoma City, OK 73128
Tel: 405-681-9710
Fax: 405-685-4006
Toll-free: 800-PL9-4142
prook1@aol.com
www.taalliance.org/ptis/ok/

Oregon

Oregon COPE Project
Jill Crawford
999 Locust St. NE
Salem, OR 97303
TDD & Tel: 503-581-8156
Fax: 503-391-0429
Toll-free: 888-505-2673
orcope@open.org
www.open.org/~orcope/

Pennsylvania

Hispanos Unidos para Niños Impedidos
(Hispanics United for Special Needs Children)
Liz Hernandez
149 W. Susquehanna Ave.
Philadelphia, PA 19122
Tel: 215-425-6203
Fax: 215-425-6204
ParentsU@aol.com
City ofPhiladelphia, occasional service to surrounding counties

Parent Education Network
Louise Thieme
333 E. 7th Ave.
York, PA 17404
TTY & Tel: 717-845-9722
Fax: 717-848-3654
Toll-free in PA: 800-522-5827
Número para llamar gratis en PA: 800-441-5028
pen@parentednet.org
www.parentednet.org

Parents Union for Public Schools
Janet Lonsdale
311 S. Juniper St., Suite 200
Philadelphia, PA 19107
Tel: 215-546-1166
Fax: 215-731-1688
ParentsU@aol.com
City of Philadelphia, occasional service to surrounding counties

Puerto Rico

APNI
Carmen Sellés deVilá
P.O. Box 21301
Ponce de Leon 724
San Juan, PR 00928-1301
Tel: 787-250-4552
Fax: 787-765-0345
Toll-free: 800-981-8492
Toll-free: 800-949-4232
apnipr@prtc.net
Island of Puerto Rico

Rhode Island

RI Parent Information Network
Annie Bisson
175 Main St.
Pawtucket, RI 02860
Tel: 401-727-4144
TDD: 401-727-4151
Fax: 401-727-4040
Toll-free in RI: 800-464-3399
bisson@ripin.org
www.ripin.org

South Carolina

PRO-PARENTS
Mary Eaddy
2712 Middleburg Dr., Suite 203
Columbia, SC 29204
TDD & Tel: 803-779-3859
Fax: 803-252-4513
Toll-free in SC: 800-759-4776
pro-parents@aol.com

South Dakota

South Dakota Parent Connection
Bev Schreck
3701 W. 49th St., Suite 200B
Sioux Falls, SD 57106
TDD & Tel: 605-361-3171
Fax: 605-361-2928
Toll-free in SD: 800-640-4553
bschreck@dakota.net
www.taalliance.org/ptis/sd/

Tennessee

Support and Training for Exceptional Parents, Inc.
Nancy Diehl
424 E. Bernard Ave., Suite 3
Greeneville, TN 37745
Tel: 423-639-0125
TDD in TN: 636-8217
Fax: 423-636-8217
Toll-free in TN: 800-280-7837
tnstep@aol.com
www.tnstep.org

Texas

El Valle Community Parent Resource Center (CPRC)
Laura Reagan
530 S. Texas Blvd., Suite J
Weslaco, TX 78596
Tel: 956-969-3611
Fax: 956-969-8761
Toll-free: 800-680-0255
laura@tflevalleycenter.org
www.tfepoder.org
Cameron, Willacy, and Starr Counties.

Grassroots Consortium
Agnes A. Johnson
6202 Belmark
P.O. Box 61628
Houston, TX 77087
Tel: 713-643-9576
Fax: 713-643-6291
SpecKids@aol.com
Composed of various community groups nationwide

Parents Supporting Parents Network (CPRC)
Margarita Tagle-Greenlees
614 N. Texas Blvd., Suite C
Weslaco, TX 78596
Tel: 956-447-8408
Fax: 512-454-4956
weslaco@gte.net

Partners Resource Network, Inc.
Janice Meyer/Michael Meyer
1090 Longfellow Dr., Suite B
Beaumont, TX 77706-4819
Tel: 409-898-4684
Fax: 409-898-4869
Toll-free: 800-866-4726
rdirector@pnx.com
www.partnerstx.org

Project P.O.D.E.R.
Yvette Hinojosa
1017 N. Main Ave., Suite 207
San Antonio, TX 78212
TDD & Tel: 210-222-2637
Fax: 210-475-9283
Toll-free TDD & Tel: 800-682-9747
poder@tfepoder.org
www.tfepoder.org
San Antonia, Hondo, Catroville, Cameron, Hidalgo, Willacy, and Starr Counties

Utah

Utah Parent Center
Helen Post
2290 E. 4500th S., Suite 110
Salt Lake City, UT 84117-4428
Tel: 801-272-1051
Número en español en UT: 801-272-1067
Fax: 801-272-8907
Toll-free in UT: 800-468-1160
Toll-free TDD in UT: 800-468-1160
upc@inconnect.com
www.utahparentcenter.org

Vermont

Vermont Parent Information Center
Connie Curtin
One Mill St., Suite A7
Burlington, VT 05401
Tel: 802-658-5315
Fax: 802-658-5395
Toll-free: 800-639-7170
vpic@together.net
homepages.together.net/~vpic/

Virgin Islands

V.I. FIND
Catherine Rehema Glenn
Two Nye Gade
St. Thomas, US VI 00802
Tel: 340-774-1662
Fax: 340-775-3962
vifind@islands.vi
www.taalliance.org/ptis/vifind/

Virginia

PADDA, Inc. (CPRC)
Mark Jacob
813 Forrest Dr., Suite 3
Newport News, VA 23606
Tel: 757-591-9119
Fax: 757-591-8990
Toll-free: 888-337-2332
webmaster@padda.org
www.padda.org

Parent Educational Advocacy Training Center
Cheri Takemoto
6320 Augusta Dr., Suite 1200
Springfield, VA 22150
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Wisconsin

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